

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17005	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD EUGENE ALEXANDER</b>										2a. DATE KNOWN OF DEATH <b>7 23 81</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>Jan. 30, 1938</b> 43 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> 7. DATE OF DEATH <b>7 23 81</b>										2b. DATE OF DEATH <b>7 23 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAC RED HEAT HOSPITAL</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Marketing Engineer</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>K-S Tire Co</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b> 13d. INSIDE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>920 East Gate Court</b>	
14. FATHER'S NAME <b>William Alexander</b> 15. MOTHER'S MAIDEN NAME <b>Angela McGlynn</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>182 28 4924</b> 17. INFORMANT <b>Phyllis Alexander, as above</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8880</b> IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Fall</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Astrocytoma, Grade III, of Brain, Radiated (four years duration)</b>											
19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19 _____ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>7/23/1981</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, MD</b> ADDRESS <b>772 BISHOP WALSH - CUMBERLAND</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>7/25/81</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Cemetery</b> 23d. LOCATION CITY OR TOWN <b>Cresaptown</b> COUNTY _____ STATE _____											
24. FUNERAL DIRECTOR NAME <b>HAFE R FUNERAL HOME, LAVALE, MARYLAND, 21502</b> ADDRESS _____ DATE REC'D. BY REGISTRAR <b>JUL 30 1981</b> REGISTRAR'S SIGNATURE <b>Giovanni Mastrangelo</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 7 0 0 6			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
MARGIE VINILA ALT				JUNE 30, 1981			
3 SEX				4 RACE			
Female				White			
5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)			
MONTH DAY YEAR				YRS.			
Oct. 6, 1912				68			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
W. Va.				USA			
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
				ALLEGANY COUNTY MD.			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
Cumberland				SACRED HEART HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Housewife							
13a. STATE				13b. COUNTY			
W. Va.				Grant			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Petersburg				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST				FIRST MIDDLE LAST			
Joseph Kimble				Annie Helmick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
no				214-62-3915			
17. INFORMANT				ADDRESS			
Norman Hinkle				Petersburg, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Ketoacidosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2501 } DUE TO, OR AS A CONSEQUENCE OF							3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
				HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				CITY OR TOWN COUNTY STATE			
STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>81</u> , to <u>6-30</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6-30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE			
Paul Livengood				MD			
22c. DATE SIGNED				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
7-2-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
PAUL LIVENGOOD, M.D.				912 SETON DRIVE CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				7-3-81			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
N. Mill Creek				CITY OR TOWN COUNTY STATE			
				Petersburg Grant W. Va.			
24. FUNERAL DIRECTOR				25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
ARNOLD FUNERAL HOME PETERSBURG, W.V.				AUG 14 1981			

WAGLE VITIA ALT 1987 1987 1987

11 MAY 1987

24000 HART WATERS

1987 1987 1987

1987 1987 1987

1987 1987 1987

1987 1987 1987

1987 1987 1987

1987 1987 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 5 G 558 8/4/81 GAB		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 17007	
1- FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) ADELE F. ANGLE			2a DATE OF DEATH MONTH DAY YEAR JULY 16, 1981		2b HOUR 1:20 P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 7-16-1898		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Allegany	13c CITY OR TOWN Westernport	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Scott Rees			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Levy		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-74-7843		17 INFORMANT ADDRESS Mr. William Angle	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MYOCARDIAL INFARCTION</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a <u>MYXEDRMA</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 7-15, 19 81, to 7-16, 19 81, that (we) lost saw the deceased alive on 7-16, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death					
22b SIGNATURE <u>Robert G. Baddock</u> DEGREE				22c. DATE SIGNED 7-17-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B RADDOCK MEDICAL GROUP				22e ADDRESS 912 SETON DRIVE, CUMBERLAND, MD. 21502	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/18/81		23c NAME OF CEMETERY OR CREMATORY St. Peter's	
23d LOCATION CITY OR TOWN Westernport		23e COUNTY Allegany		23f STATE Md.	
24 FUNERAL DIRECTOR NAME FREDLOCK FUNERAL HOME PIEDMONT, WV. 26750		24b ADDRESS Wm. H. Fredlock		25 DATE REGD. BY REGISTRAR JUL 23 1981	

ADJUTANT GENERAL'S OFFICE  
WASHINGTON, D.C. 20315  
JULY 12, 1961  
AIRTEL

ALLEGANY COUNTY

SACRED HEART HOSPITAL

WADSWORTH MEDICAL GROUP  
912 SECON DIVE, CUMBERLAND, MD. 21501

STATION FIVE AT HOME BRIGHT, W.V. 26750

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director. 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) PEARL D. ASHENFELTE R (Pearl D. Ashenfelter)							2a. DATE OF DEATH MONTH DAY YEAR JULY 25, 1981		2b. HOUR 6:42 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va. 13b. COUNTY Mineral 13c. CITY OR TOWN Ridgeley							13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1		
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Ashenfelter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Blackburn				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS Mr. Wayne E. Ashenfelter, Ridgeley, W. Va.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>metastatic &amp; recurrent rectal Ca</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.											
22b. SIGNATURE <i>C. J. Flores</i> DEGREE						22c. DATE SIGNED 7/25/81			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. AUDERTO FLORES						22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-28-1981		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME SCARPELLI FUNERAL HOME CUMBERLAND, MD						25. DATE SIGNED BY REGISTRAR JUL 31 1981			26. REGISTRAR'S SIGNATURE <i>James J. Martin</i>		



BEAL D. ASHERBETH 1901

ALLEGANY COUNTY

SACRED HEART HOSPITAL

Isabelle Lincoln

Charles S. Asherbeth

Wm. L. Asherbeth, Bishop, N.Y.

IR. AUDERT FLOPP

7-20-1901

Isabelle

SACRED HEART HOME - CUMBERLAND, N.Y.

108 VIRGINIA AVE. JUL 11

Isabelle Asherbeth, Bishop, N.Y.

921 SETON DRIVE, CUMBERLAND, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 17009	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JUANITA ALLENE ATHEY			2a. DATE OF DEATH MONTH DAY YEAR JULY 13, 1981		2b. HOUR 2:50 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
12. CITY OR TOWN OF DEATH Cumberland	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		14. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Seamstress		15. KIND OF BUSINESS OR INDUSTRY Sewing
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va. 13b. COUNTY Mineral 13c. CITY OR TOWN Keyser			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 18. STREET ADDRESS 315 E. Street		
19. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Wageley			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel M. Buckley		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No None			22. SOCIAL SECURITY NO. 213-24-6521		
23. INFORMANT Irving T. Athey, 315 E.St., Keyser, W.Va.			24. ADDRESS		
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Due to</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Tyr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE	
36. I certify that (I) (this hospital) attended the deceased from <u>July 6, 1980</u> to <u>July 13, 1981</u> that (I) (we) lost saw the deceased alive on <u>July 6, 1980</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
37. SIGNATURE <u>W. C. Spiggle</u>		38. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		39. DATE SIGNED July 14/81	
40. PHYSICIAN'S NAME (TYPE OR PRINT) W. C. SPIGGLE, M.D.		41. ADDRESS 912 SETON DRIVE, CUMBERLAND, MD 21502			
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		43. DATE July 15, 1981		44. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens	
45. LOCATION CITY OR TOWN COUNTY STATE Keyser Mineral W.Va.		46. FUNERAL DIRECTOR NAME MARKWOOD FUNERAL HOME 11 MINERAL ST., KEYSER, WV 26726			



UNITED STATES ARMY

MAY 15, 1951

ALLEGANY COUNTY

ST. GEORGE HOSPITAL

510-2-5521

410 SEVEN DRIVE, CUMBERLAND, MD. 21502

W. C. SPIGGLIE, M.D.

MARKED BY SPINAL POINT IN HOSPITAL ST. GEORGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 1 7 0 1 0	
1 - DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
RUSSELL NMI BENNETT		7 2 81		8 15 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7b. HOUR	
Male	White	August 22, 1887	93 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Penna.	U. S. A.		Allegany MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland,	Allegany Nursing Home,	Ret. Factory Wkr.	Kelly Tire Co.		
13a. COUNTY		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
Maryland	Allegany	Cumberland,	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Formerly 309 Arch St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Abraham -- Bennett		Josephine -- Shaffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.		212-18-1566		Cumberland, Md.	
		Ernest B. Billmeyer, Sr.		617 Elwood St. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b) Coronary Sclerosis		approx. 12 hrs.	
		DUE TO, OR AS A CONSEQUENCE OF		year	
		Cor. Arterio-sclerotic Cardio-vascular disease		year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Chronic Pulmonary TBC Sensitivity. Secondary HT. I's					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8 22 19 77 to 7 2 19 81, that (I) (we) last saw the deceased alive on 7 8 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		John A. Toffler MD		7 3 81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
John A. Toffler MD		Nyxman Pa 15545			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7/5/81		Zion Memorial Cem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
H. Wayne George 202 Greene St. Cumberland, Md.		JUL 8 1981		Name: [Signature]	

ONE OF TWO

RECEIVED

DATE: 11-11-1961

TO: Mr. J. Edgar Hoover

FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]

RE: [Illegible]

11-11-1961

11-11-1961

[Illegible]

11-11-1961

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 416-352-1100.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
GEORGE GRAM BILLINGS					JULY 14, 1981				5:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	MONTH DAY YEAR 09 26 13		67 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
DELAWARE	USA			ALLEGANY COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND, MD	SACRED HEART HOSPITAL			PIPEFITTER		COMMUNICATIONS			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
MD		GARRETT		GANTSVILLE		RT. 2 BOX 13 A			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
HARRY BILLINGS		HATTIE GRAHAM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO		213-07-1467		LAVONNE BILLINGS (wife) Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable CHF.</u> 2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } b. <u>ASHD - Renal failure.</u> DUE TO, OR AS A CONSEQUENCE OF } c. <u>Diabetes.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>occlusive vascular disease -</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>7-12</u> 19 <u>81</u> to <u>7-14</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>7-13</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John Mehan</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-14-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, .MD.				22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE 7-15-81		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
24. FUNERAL DIRECTOR NAME <u>anatomy</u>		24b. ADDRESS <u>2550 Balto.</u>		25a. DATE REC'D. BY REGISTRAR JUL 16 1981		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>			

BP

21-



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 17 0 1 2	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
LOUIS HENRY BROBST				JULY 17, 1981	
3 SEX		4. RACE		5. DATE OF BIRTH	
Male		White		March 13, 1905	
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
Pennsylvania		USA		76 YRS.	
7a. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
CUMBERLAND		MEMORIAL HOSPITAL		Allegany MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Retired		Textile			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Allegany		Cumberland	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
Joseph Brobst		Ida Colehouse		327 Fort Hill Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		217-10-6771		Mrs. Hazel Brobst, Cumberland, Md. Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory Failure					
5188 DUE TO, OR AS A CONSEQUENCE OF					
(b) Respiratory insufficiency					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Chronic Lung Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Carcinoma of the Lung					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
DR. AMADO P. TORRES					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
				MEMORIAL HOSPITAL, MED. BLDG., CUMBERLAND, MARYLAND 21502	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-20-1981		Hillcrest Burial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Cumberland, Allegany, Md.		JUL 22 1981		James F. Scarpelli	

BP

DHMH-16 30M 2/80  
(VRA 15, 4)



1:00p

JULY 17, 1951

REPORT

HENRY

LOUIS

Case

Date

July 12, 1951

Emergency

See

Allegation

CUMBERLAND

MEMORIAL HOSPITAL

Office

Textile

Residence

Allegation

Understand

See Fort All over

Fourth report

The following

See

Case file

NY-10-100

See, New York, New York, New York, N.Y.

DR. ARTHUR P. TORRES

MEMORIAL HOSPITAL AND CLINIC  
CUMBERLAND, MARYLAND 21502

7-20-51

Allegation, New York, New York, N.Y.

See: New York, New York, N.Y.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OF THE DEATH. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Elizabeth Brown</b>		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>7 30 19 81</b>		2b. HOUR <b>6:30 P M</b>	
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>July 18 19 15</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>		MD			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>443 Bond Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>443 Bond Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl W. Miller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Lavin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 42 0148</b>		17. INFORMANT ADDRESS <b>Frank J. Brown Cumberland, MD Husband</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Hypertension</b> (c) <b>Arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ----- <b>months</b> <b>years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Francisco Reyes</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>July-30-81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes, M.D.</b>		ADDRESS <b>Cumberland, Maryland 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Pk.</b>	
23d. LOCATION <b>Cumberland Allegany MD</b>		MD			
24. FUNERAL DIRECTOR NAME <b>JAMES F. SCARPELLI</b>		ADDRESS <b>CUMBERLAND, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



2

~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 7 0 1 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>STEPHEN Lamar BROWN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 8 1981</b>			
3. SEX <b>MALE</b>				2b. HOUR <b>125 A.M.</b>			
4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 02 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegheny</b> MD.				10. CITY OR TOWN OF DEATH <b>Cumberland</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CUMBERLAND NURSING &amp; CONVALESCENT HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>			
12b. KIND OF BUSINESS OR INDUSTRY <b>Textile Corp.</b>				13a. STREET ADDRESS <b>12110 McMullen Hwy.</b>			
13b. COUNTY <b>Allegheny</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William — Brown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary — Handack</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>217-10-7417</b>		17. INFORMANT <b>MRS. Helen R. Brown</b>		18. ADDRESS <b>12110 McMullen Hwy. Cumb. MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>ACVD</b>							<b>2 days</b>
4292							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Parkinson's disease</b>							
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>03-15-</b> 19 <b>81</b> , to <b>07-08</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>07-06</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Martin M. Rothstein M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>07/08/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN M. ROTHSTEIN M.D.</b>				22e. ADDRESS <b>48 BROADWAY - FROSTBURG MD-21532</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 10, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegheny MD.</b>	
24. FUNERAL DIRECTOR NAME <b>H. Wayne George</b>				25. DATE REC'D. BY REGISTRAR <b>JUL 13 1981</b>			

BP

2012-10-10 10:10:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 17015	
1. FOR STATE REGISTRAR										REG NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>De Sales Byrnes</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 11, 1981</b>			2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 26, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Allegany County Nurseing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK, FORMER, OR OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Celanease</b>			
13a. STATE <b>Md</b>					13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Byrnes</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Mills</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Rev. Paul Byrnes Oakland, Md</b>						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus Previous CVD.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>January 6, 1981</b> to <b>July 11, 1981</b> , that (I) (we) last saw the deceased alive on <b>July 11, 1981</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I, d.) (did not) view the body after death.											
22b. SIGNATURE <b>Ralph P. Erdly M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>July 12, 1981</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ralph P. Erdly</b>					22e. ADDRESS <b>44 Scott Court Bel Air</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/14/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lonaconing A. Md</b>				
24. FUNERAL DIRECTOR NAME <b>Eichhorn Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1981</b>						
ADDRESS <b>Lonaconing, Md</b>					25b. REGISTRAR'S SIGNATURE <b>Anne Jan...</b>						

MEDICAL CERTIFICATION

od i

• • •



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
ELLEN LAURA CARROLL		July 26 81		8 32 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	WHITE	MONTH DAY YEAR	85 YRS	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. DATE OF BIRTH	11. AGE (IN YEARS LAST BIRTHDAY)	12. IF UNDER 24 HRS	
MARYLAND	USA	APRIL 4 1896	85 YRS	MONTHS DAYS HOURS MIN.	
13. CITY OR TOWN OF DEATH	14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	15. BALTIMORE CITY OR COUNTY OF DEATH	16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	17. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND	ALLEGANY CO NURSING HOME	ALLEGANY MD	RETIRED RETAIL CLERK		
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	19. INSIDE CITY LIMITS?	20. STREET ADDRESS	21. MOTHER'S MAIDEN NAME		
MARYLAND	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	308 CUMBERLAND STREET	MARY R. MOOREHEAD		
22. FATHER'S NAME	23. MOTHER'S MAIDEN NAME	24. ADDRESS			
JOHN T. TAYLOR	MARY R. MOOREHEAD	1035 FREDERICK ST. CUMBERLAND MD.			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	26. SOCIAL SECURITY NO.	27. INFORMANT			
NO	220-03-7705A	MRS ROBERT DAVIDSON			
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Severe Congestive Heart failure.</u> (b) <u>4140</u> (c) <u>Chronic atherosclerotic Heart Disease years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Multiple Grade IV decubitus - severe. Lower W.T.I. Diabetes</u>					
29. DATE OF OPERATION	30. CONDITION FOR WHICH OPERATION WAS PERFORMED	31. AUTOPSY			
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	33. TIME OF INJURY	34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M.				
35. INJURY OCCURRED	36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	37. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
38. I certify that (I) (this hospital) attended the deceased from <u>July 26</u> 19 <u>81</u> to <u>July 26</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>July 26</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
39. SIGNATURE	40. DEGREE	41. DATE SIGNED			
<u>John A. Topper</u>	<u>MD</u>	<u>7 27 81</u>			
42. PHYSICIAN'S NAME (TYPE OR PRINT)	43. ADDRESS	44. DATE REC'D. BY REGISTRAR			
<u>John A. Topper MD</u>	<u>Hyndman Co 15545</u>	<u>JUL 30 1981</u>			
45. BURIAL, CREMATION, REMOVAL (SPECIFY)	46. DATE	47. NAME OF CEMETERY OR CREMATORY			
BURIAL	JULY 29 1981	HILLCREST BURIAL PARK			
48. FUNERAL DIRECTOR	49. ADDRESS	50. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERVICE	CUMBERLAND MD.	<u>Phyllis J. [Signature]</u>			

1951 10 26 100

CLERK

ADMIN

RECORD

82

APRIL 1 1906

WHITE

CLARK

WILLIAM

XX

189

WILLIAM

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

2

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

WILLIAM WILLIAM CLARK

BP  
DHMH-16 50M 1/BI  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>IVA CATHERINE CRAMER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 16, 1981</b>		2b. HOUR <b>5:30 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 15 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		9. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>			
12. CITY OR TOWN OF DEATH <b>Cumberland</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Pa.</b> 16b. COUNTY <b>Somerset</b> 16c. CITY OR TOWN <b>Fort Hill</b>						17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS <b>R. D. 1 Fort Hill</b>	
19. FATHER'S NAME FIRST MIDDLE LAST <b>William Frazee</b>				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elmire Ringer</b>					
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b> (IF YES, GIVE WAR OR DATES)				22. SOCIAL SECURITY NO. <b>201-42-6726</b>		23. INFORMANT ADDRESS <b>Luther Cramer R. D. 1 Fort Hill, Pa. 15540</b>			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1629 Carcinoma of Lung</b> IMMEDIATE CAUSE (a) <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
25. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Atherosclerosis</b>									
26. DATE OF OPERATION				27. CONDITION FOR WHICH OPERATION WAS PERFORMED				28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				34. LOCATION STREET CITY OR TOWN COUNTY STATE	
35. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
36. SIGNATURE <b>Wm. J. Newman</b>						37. DEGREE <b>M.D.</b>		38. DATE SIGNED <b>7-16-81</b>	
39. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BMG.</b>						40. ADDRESS <b>912 SETON DRIVE, CUMBERLAND, MD. 21502</b>			
41. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		42. DATE <b>July 18, 81</b>		43. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		44. LOCATION CITY OR TOWN COUNTY STATE <b>Fort Hill Somerset Pa.</b>		45. DATE REC'D. BY REGISTRAR	
46. FUNERAL DIRECTOR (NAME) <b>Don J. Newman Grantsville Md.</b>						47. REGISTRAR'S SIGNATURE <b>James J. Newman</b>			
48. HUMBOLDT FUNERAL HOME, CONFLUENCE, PA									

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-442611)  
FROM : SAC, NEW YORK (100-100000) (P)  
SUBJECT: [REDACTED] (C)  
RE: [REDACTED] (C)

1. [REDACTED] (C)

2. [REDACTED] (C)

3. [REDACTED] (C)

4. [REDACTED] (C)

5. [REDACTED] (C)

6. [REDACTED] (C)

7. [REDACTED] (C)

8. [REDACTED] (C)

9. [REDACTED] (C)

10. [REDACTED] (C)

11. [REDACTED] (C)

12. [REDACTED] (C)

13. [REDACTED] (C)

14. [REDACTED] (C)

15. [REDACTED] (C)

16. [REDACTED] (C)

17. [REDACTED] (C)

18. [REDACTED] (C)

19. [REDACTED] (C)

20. [REDACTED] (C)

21. [REDACTED] (C)

22. [REDACTED] (C)

23. [REDACTED] (C)

24. [REDACTED] (C)

25. [REDACTED] (C)

26. [REDACTED] (C)

27. [REDACTED] (C)

28. [REDACTED] (C)

29. [REDACTED] (C)

30. [REDACTED] (C)

31. [REDACTED] (C)

32. [REDACTED] (C)

33. [REDACTED] (C)

34. [REDACTED] (C)

35. [REDACTED] (C)

36. [REDACTED] (C)

37. [REDACTED] (C)

38. [REDACTED] (C)

39. [REDACTED] (C)

40. [REDACTED] (C)

41. [REDACTED] (C)

42. [REDACTED] (C)

43. [REDACTED] (C)

44. [REDACTED] (C)

45. [REDACTED] (C)

46. [REDACTED] (C)

47. [REDACTED] (C)

48. [REDACTED] (C)

49. [REDACTED] (C)

50. [REDACTED] (C)

51. [REDACTED] (C)

52. [REDACTED] (C)

53. [REDACTED] (C)

54. [REDACTED] (C)

55. [REDACTED] (C)

56. [REDACTED] (C)

57. [REDACTED] (C)

58. [REDACTED] (C)

59. [REDACTED] (C)

60. [REDACTED] (C)

61. [REDACTED] (C)

62. [REDACTED] (C)

63. [REDACTED] (C)

64. [REDACTED] (C)

65. [REDACTED] (C)

66. [REDACTED] (C)

67. [REDACTED] (C)

68. [REDACTED] (C)

69. [REDACTED] (C)

70. [REDACTED] (C)

71. [REDACTED] (C)

72. [REDACTED] (C)

73. [REDACTED] (C)

74. [REDACTED] (C)

75. [REDACTED] (C)

76. [REDACTED] (C)

77. [REDACTED] (C)

78. [REDACTED] (C)

79. [REDACTED] (C)

80. [REDACTED] (C)

81. [REDACTED] (C)

82. [REDACTED] (C)

83. [REDACTED] (C)

84. [REDACTED] (C)

85. [REDACTED] (C)

86. [REDACTED] (C)

87. [REDACTED] (C)

88. [REDACTED] (C)

89. [REDACTED] (C)

90. [REDACTED] (C)

91. [REDACTED] (C)

92. [REDACTED] (C)

93. [REDACTED] (C)

94. [REDACTED] (C)

95. [REDACTED] (C)

96. [REDACTED] (C)

97. [REDACTED] (C)

98. [REDACTED] (C)

99. [REDACTED] (C)

100. [REDACTED] (C)

101. [REDACTED] (C)

102. [REDACTED] (C)

103. [REDACTED] (C)

104. [REDACTED] (C)

105. [REDACTED] (C)

106. [REDACTED] (C)

107. [REDACTED] (C)

108. [REDACTED] (C)

109. [REDACTED] (C)

110. [REDACTED] (C)

111. [REDACTED] (C)

112. [REDACTED] (C)

113. [REDACTED] (C)

114. [REDACTED] (C)

115. [REDACTED] (C)

116. [REDACTED] (C)

117. [REDACTED] (C)

118. [REDACTED] (C)

119. [REDACTED] (C)

120. [REDACTED] (C)

121. [REDACTED] (C)

122. [REDACTED] (C)

123. [REDACTED] (C)

124. [REDACTED] (C)

125. [REDACTED] (C)

126. [REDACTED] (C)

127. [REDACTED] (C)

128. [REDACTED] (C)

129. [REDACTED] (C)

130. [REDACTED] (C)

131. [REDACTED] (C)

132. [REDACTED] (C)

133. [REDACTED] (C)

134. [REDACTED] (C)

135. [REDACTED] (C)

136. [REDACTED] (C)

137. [REDACTED] (C)

138. [REDACTED] (C)

139. [REDACTED] (C)

140. [REDACTED] (C)

141. [REDACTED] (C)

142. [REDACTED] (C)

143. [REDACTED] (C)

144. [REDACTED] (C)

145. [REDACTED] (C)

146. [REDACTED] (C)

147. [REDACTED] (C)

148. [REDACTED] (C)

149. [REDACTED] (C)

150. [REDACTED] (C)

151. [REDACTED] (C)

152. [REDACTED] (C)

153. [REDACTED] (C)

154. [REDACTED] (C)

155. [REDACTED] (C)

156. [REDACTED] (C)

157. [REDACTED] (C)

158. [REDACTED] (C)

159. [REDACTED] (C)

160. [REDACTED] (C)

161. [REDACTED] (C)

162. [REDACTED] (C)

163. [REDACTED] (C)

164. [REDACTED] (C)

165. [REDACTED] (C)

166. [REDACTED] (C)

167. [REDACTED] (C)

168. [REDACTED] (C)

169. [REDACTED] (C)

170. [REDACTED] (C)

171. [REDACTED] (C)

172. [REDACTED] (C)

173. [REDACTED] (C)

174. [REDACTED] (C)

175. [REDACTED] (C)

176. [REDACTED] (C)

177. [REDACTED] (C)

178. [REDACTED] (C)

179. [REDACTED] (C)

180. [REDACTED] (C)

181. [REDACTED] (C)

182. [REDACTED] (C)

183. [REDACTED] (C)

184. [REDACTED] (C)

185. [REDACTED] (C)

186. [REDACTED] (C)

187. [REDACTED] (C)

188. [REDACTED] (C)

189. [REDACTED] (C)

190. [REDACTED] (C)

191. [REDACTED] (C)

192. [REDACTED] (C)

193. [REDACTED] (C)

194. [REDACTED] (C)

195. [REDACTED] (C)

196. [REDACTED] (C)

197. [REDACTED] (C)

198. [REDACTED] (C)

199. [REDACTED] (C)

200. [REDACTED] (C)

201. [REDACTED] (C)

202. [REDACTED] (C)

203. [REDACTED] (C)

204. [REDACTED] (C)

205. [REDACTED] (C)

206. [REDACTED] (C)

207. [REDACTED] (C)

208. [REDACTED] (C)

209. [REDACTED] (C)

210. [REDACTED] (C)

211. [REDACTED] (C)

212. [REDACTED] (C)

213. [REDACTED] (C)

214. [REDACTED] (C)

215. [REDACTED] (C)

216. [REDACTED] (C)

217. [REDACTED] (C)

218. [REDACTED] (C)

219. [REDACTED] (C)

220. [REDACTED] (C)

221. [REDACTED] (C)

222. [REDACTED] (C)

223. [REDACTED] (C)

224. [REDACTED] (C)

225. [REDACTED] (C)

226. [REDACTED] (C)

227. [REDACTED] (C)

228. [REDACTED] (C)

229. [REDACTED] (C)

230. [REDACTED] (C)

231. [REDACTED] (C)

232. [REDACTED] (C)

233. [REDACTED] (C)

234. [REDACTED] (C)

235. [REDACTED] (C)

236. [REDACTED] (C)

237. [REDACTED] (C)

238. [REDACTED] (C)

239. [REDACTED] (C)

240. [REDACTED] (C)

241. [REDACTED] (C

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sadie Mae Durst</b>			2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MATED <b>July 6, 1981</b>			7. HOUR <b>1:52 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1906</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>75 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>July 6, 1981</b>	7d. HOUR <b>1:52 P.M.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bubber</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Cumberland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. #3 Box #54 Bedford Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Brotemarkle</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Kerns</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-05-9832</b>		17. INFORMANT ADDRESS <b>Mr. Howard W. Durst Rt. #3 Box 54 Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>4100</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>July 7, 1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b>		ADDRESS <b>Sacred Heart Hosp. Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 8, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Silcox-Merritt Fun'l Ser. 404 Decatur St. Cumberland, Md.</b>							

DATE REC'D BY REGISTRAR  
**JUL 9 1981**  
REGISTRAR'S SIGNATURE  
**Giovanni Mastrangelo**

atherosclerotic Heart Disease  
 and Occlusion

Affiant

I, the undersigned, being a duly qualified physician and surgeon, do hereby certify that the above-named patient is suffering from atherosclerotic heart disease and occlusion.

Witness my hand and seal this 1st day of July, 1951.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. IF THE DELAY IS MORE THAN 24 HOURS, THE EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

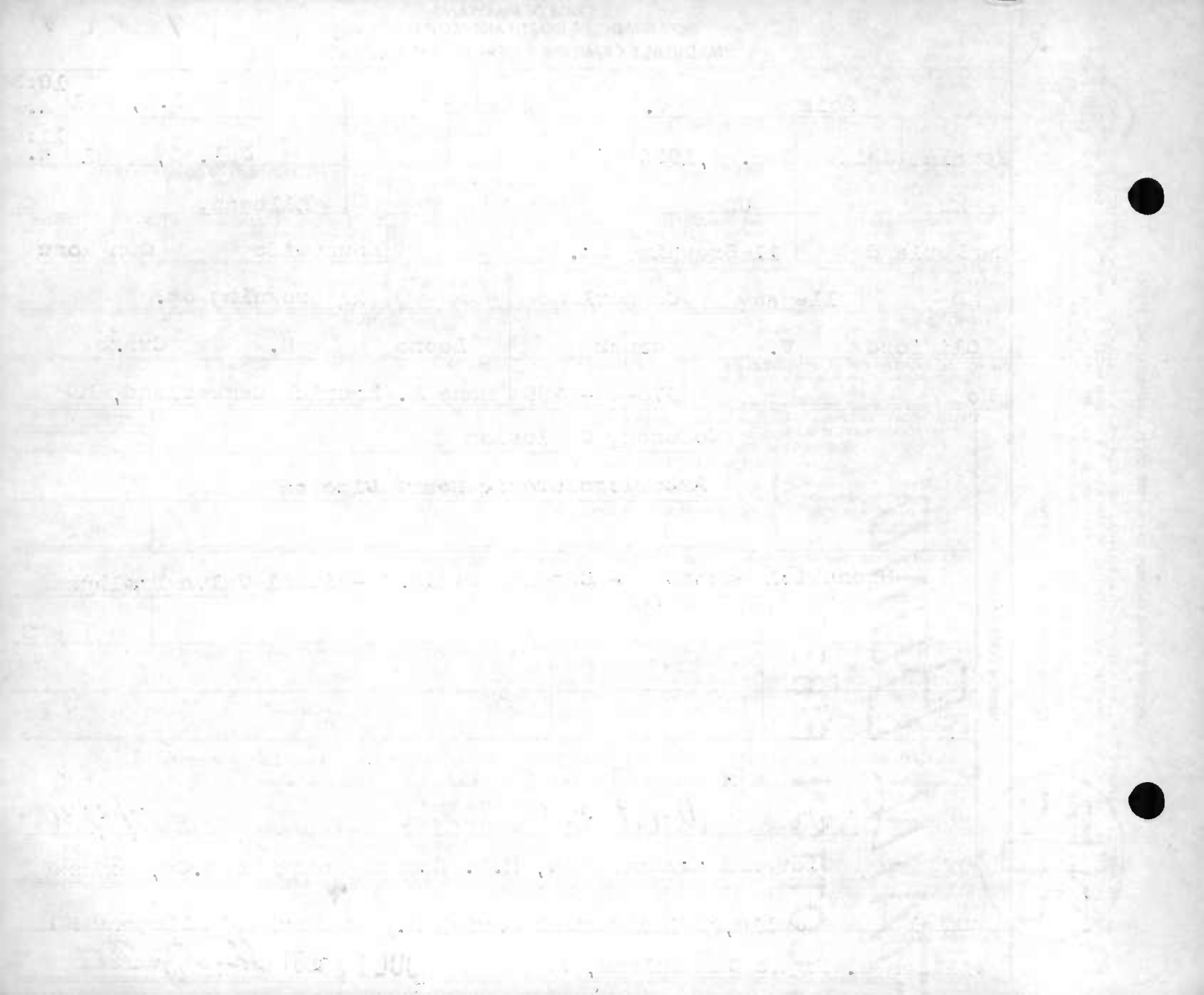
DHAM - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Lois		MIDDLE V.		LAST Emerick		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH Jul. 8, 1981		DAY 8		YEAR 1981		10- HOUR A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1935		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jul. 8, 1981		2d. HOUR 11:00 a.m.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Browning St.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. STATE MD				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 11 Browning St.			
14. FATHER'S NAME FIRST MIDDLE LAST Clifford V. Ranck								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leona M. Craze											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-46-8265				17. INFORMANT Zane L. Emerick								ADDRESS Cumberland, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Bronchial Asthma - Cardiac Failure - Mitral Valve Prolapse																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Giovanni Mastrangelo				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 7/8/81							
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D.				ADDRESS Sacred Heart Hosp. Cumberland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jul 10, 1981				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial P.				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD							
24. FUNERAL DIRECTOR NAME William G. Kight				ADDRESS Cumberland, MD				25a. DATE REC'D. BY REGISTRAR JUL 13 1981				25b. REGISTRAR'S SIGNATURE [Signature]							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
FIRST MIDDLE LAST <b>ALBERT LEE FRIEND</b>			MONTH DAY YEAR <b>JULY 11, 1981</b>			MONTH DAY YEAR <b>8:00 P.M.</b>		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
<b>Male</b>	<b>White</b>	MONTH DAY YEAR <b>Dec 13 1914</b>	<b>66 YRS.</b>			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
<b>Maryland</b>	<b>U.S.A.</b>		<b>ALLEGANY COUNTY MD.</b>					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
<b>Cumberland</b>	<b>SACRED HEART HOSPITAL</b>			<b>Retired Employee</b>			<b>Tire Co</b>	
13a STATE			13b COUNTY			13c CITY OR TOWN		
<b>Maryland</b>			<b>Allegany</b>			<b>LaVale</b>		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e STREET ADDRESS		
<b>Vestus C Friend</b>			<b>Fannie Jeannette DeWitt</b>			<b>934 Atlantic Avenue</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
<b>Yes WWII</b>			<b>220-03-7694</b>			<b>Mrs. Alice M. Friend LaVale, Maryland</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C. V. A. (lt. Side).</b> <b>4349</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Spelled St. Cerebral Hemiparesis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>St. Carotid Artery Endarterectomy. Abdominal Aortic Aneurysm</b>								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <b>C. J. Vincent M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>CLARENCE VINCENT, M.D.</b>						22e ADDRESS <b>909-B SETON DRIVE, CUMBERLAND, MD 21502</b>		
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
<b>Burial</b>			<b>July 14, 1981</b>		<b>Rest Lawn Mem Gardens</b>		<b>LaVale Allegany Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>SILCOX - MERRITT FUNERAL HOME</b>						25. DATE REC'D. BY REGISTRAR <b>JUL 16 1981</b>		



ALBERT LEE FRIEND JULY 11, 1981 8:00 P

Male	White	Doc 13 1974	68
Maryland	U.S.A.		
Quilboring	SACRED HEART HOSPITAL	Bellevue Hospital	Five Co
Maryland	Allegany	LeVale	934 Atlantic Avenue
LeVale	Friend	LeVale	934 Atlantic Avenue
LeVale	Friend	LeVale	934 Atlantic Avenue
LeVale	Friend	LeVale	934 Atlantic Avenue

*[Faint, illegible handwritten notes and signatures]*

CLARENCE VINCENT, M.L.  
 902 E SETON DRIVE, CUMBERLAND, MD 21502  
 July 11, 1981  
 934 Atlantic Avenue  
 Bellevue Hospital  
 Five Co

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 7 0 2 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLAYTON JOHN GARLITZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 27, 1981</b>		2b. HOUR <b>7:50 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 9, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF INDUSTRY OR MOST OF WORKING LIFE) <b>TEXTILE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CORP.</b>	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>FROSTBURG</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS <b>RT. 2, BOX 244</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN A. GARLITZ</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>ELLA HEMMING</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-16-4685</b>	17. INFORMANT ADDRESS <b>RD 2</b> <b>DOROTHY L. GARLITZ, FROSTBURG, MD.</b>		
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <b>5621</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Pneumonia, Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> <b>2 hrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Parkinsonism, ASCVD, Colicoid</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>George M. Breza</u> MD		DEGREE		22c. DATE SIGNED <b>7/27/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE M. BREZA, M.D.</b>		22e. ADDRESS <b>BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-29-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG, ALLEG., MD.</b>
24. FUNERAL DIRECTOR NAME <b>DURST FUNERAL HOME, FROSTBURG, MD 21532</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 5 1981</b>		25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>	

35  
50  
35  
10  
1  
2  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



7:50 A

JULY 21, 1961

CARLITE

JOHN

CLAYTON

TO

AT 10:00 AM

WHITE

HAIR

ALLEGANY COUNTY

U.S.A.

RECEIVED

SACRED HEART HOSPITAL

CHURCH

U.S.A. 21-100

RECEIVED

RECEIVED

RECEIVED

RECEIVED

U.S.A.

RECEIVED

U.S.A. 21-100

RECEIVED

RECEIVED

U.S.A. 21-100

RECEIVED

RECEIVED

RECEIVED

U.S.A. 21-100

RECEIVED

RECEIVED

27 FIRST AVE.

FIRST FURNACE HOME, FROSTBURG, MD 21512

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

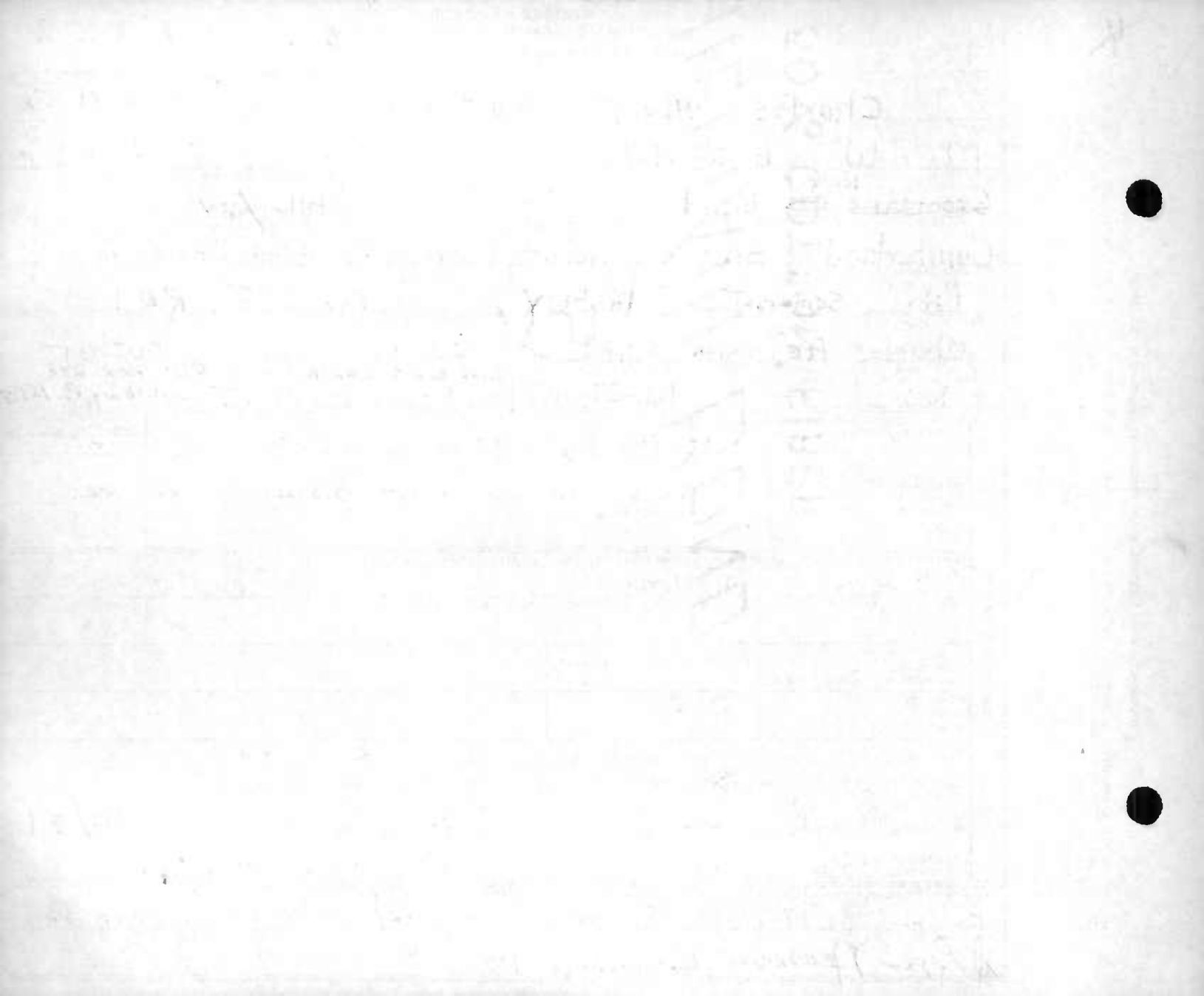
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Albert Gartner</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>7 13 1981</b>		2b. HOUR 5:41 P.M.
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 28 1929</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>52</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Graessville, Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled LABORER</b>	
13a. STATE <b>PA.</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Salisbury</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles FREDERICK Gartner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>cora Ann Butler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>166-24-9019</b>		17. INFORMANT <b>MRS. LORIS GARTNER - ADDRESS RDI Box 238 In Fd - OFF old Chart Salisbury, Pa. 15358</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>(b) CORONARY ARTERY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1MM.</b> <b>XRS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a <b>DIABETES mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Paul Snow</b>		TITLE (SPECIFY) <b>M.D. D.P.</b>		MEDICAL EXAMINER <b>DATE SIGNED 7/13/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow</b>		ADDRESS <b>Memorial Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-17-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SALISBURY CEMETERY</b>	
24. FUNERAL DIRECTOR NAME <b>John Newman</b>		ADDRESS <b>GRANTVILLE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. Heston</b>					

Lch





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

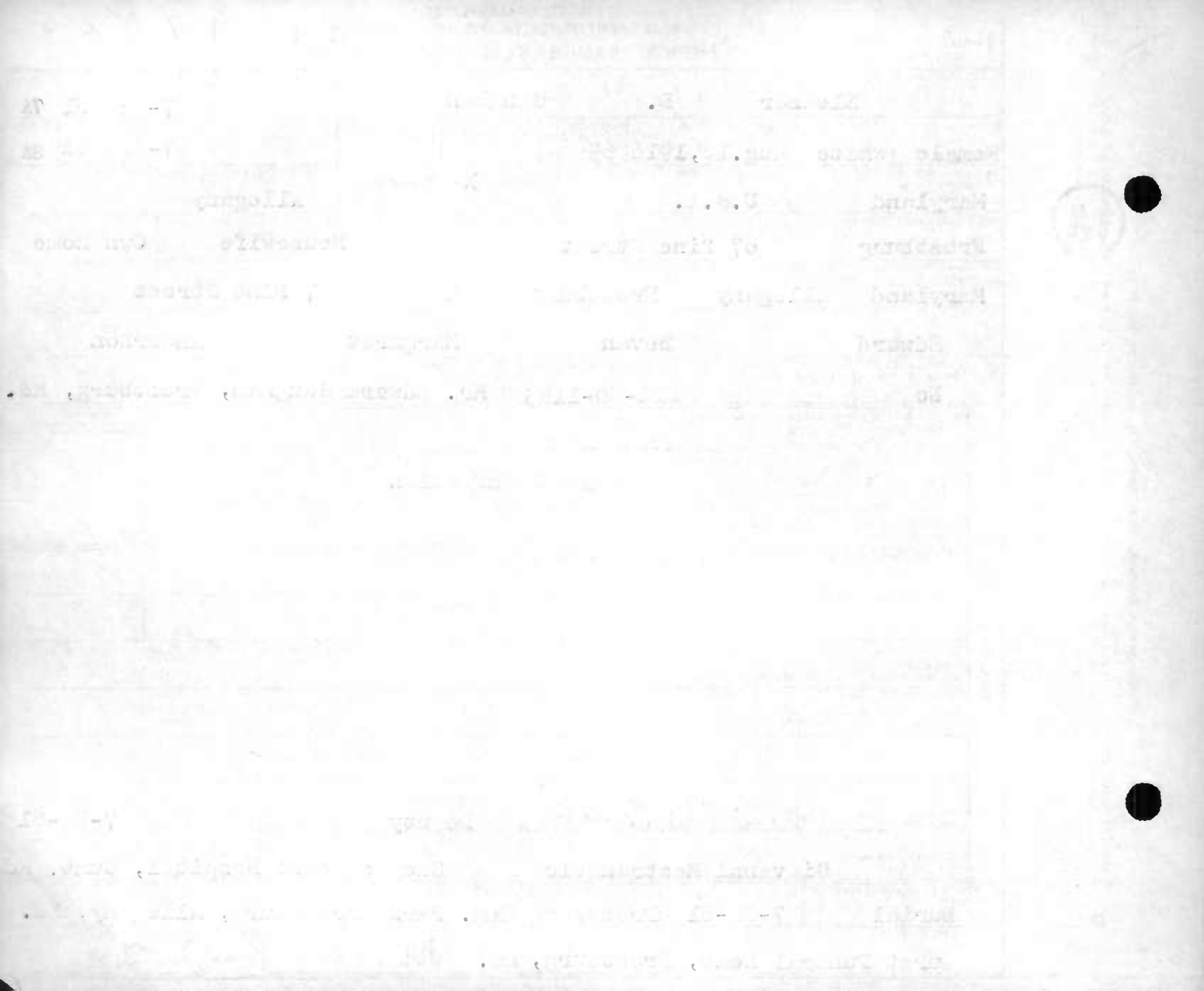
DHMH - 17  
(VRA 15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Eleanor B. Gaughan</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-22 19 81		2b. HOUR 7A M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 18, 1916</b>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>65</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>67 Pine Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Frostburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Bevan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Anderson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-80-1143</b>		17. INFORMANT ADDRESS <b>Mr. Edward Gaughan, Frostburg, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>Bacterial Infection</b> (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>		TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER		DATE SIGNED <b>7-22-81</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo</b>		ADDRESS <b>Sacred Heart Hospital, Cumb. Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>7-24-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1981</b>		
		25b. REGISTRAR'S SIGNATURE <i>James J. Mastrangelo</i>		





1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 17024

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH A G RABENSTEIN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JULY 31, 1981</b>			2b HOUR <b>M</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 21, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.			
10 CITY OR TOWN OF DEATH <b>Cumberland</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a STATE <b>MD</b>			13b COUNTY <b>Allegany</b>		13c CITY OR TOWN <b>Cumberland</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George S. Benson</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie M. Peterman</b>					13e STREET ADDRESS <b>Rt. 4, Box 8 Oldtown Road</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220 10 2545</b>		17 INFORMANT ADDRESS <b>Raphel H. Grabenstein Cumberland, MD</b>				

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension with renal failure</b> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>7-22</b> , 19 <b>81</b> to <b>7-31</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>7-30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.							
22b SIGNATURE <b>John Mehanua</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>7-31-81</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN MEHANUA, M.D.</b>				22e ADDRESS <b>909-B SETON DRIVE, CUMBERLAND, MD 21502</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>8-3-81</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany MD</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>SCARPELLI FUNERAL HOME, 108 VIRGINIA AVE., CUMBERLAND, MD</b>				25 DATE REC'D. BY REGISTRAR <b>AUG 5 1981</b>		26 REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



21502

JOHN P. BROWN, JR.  
300-B SECON DRIVE, CUMBERLAND, MD.  
CUMBERLAND, MD.  
108 VIRGINIA AVE. Rm. 101  
CUMBERLAND, MD.

Birth date 8/16/1967

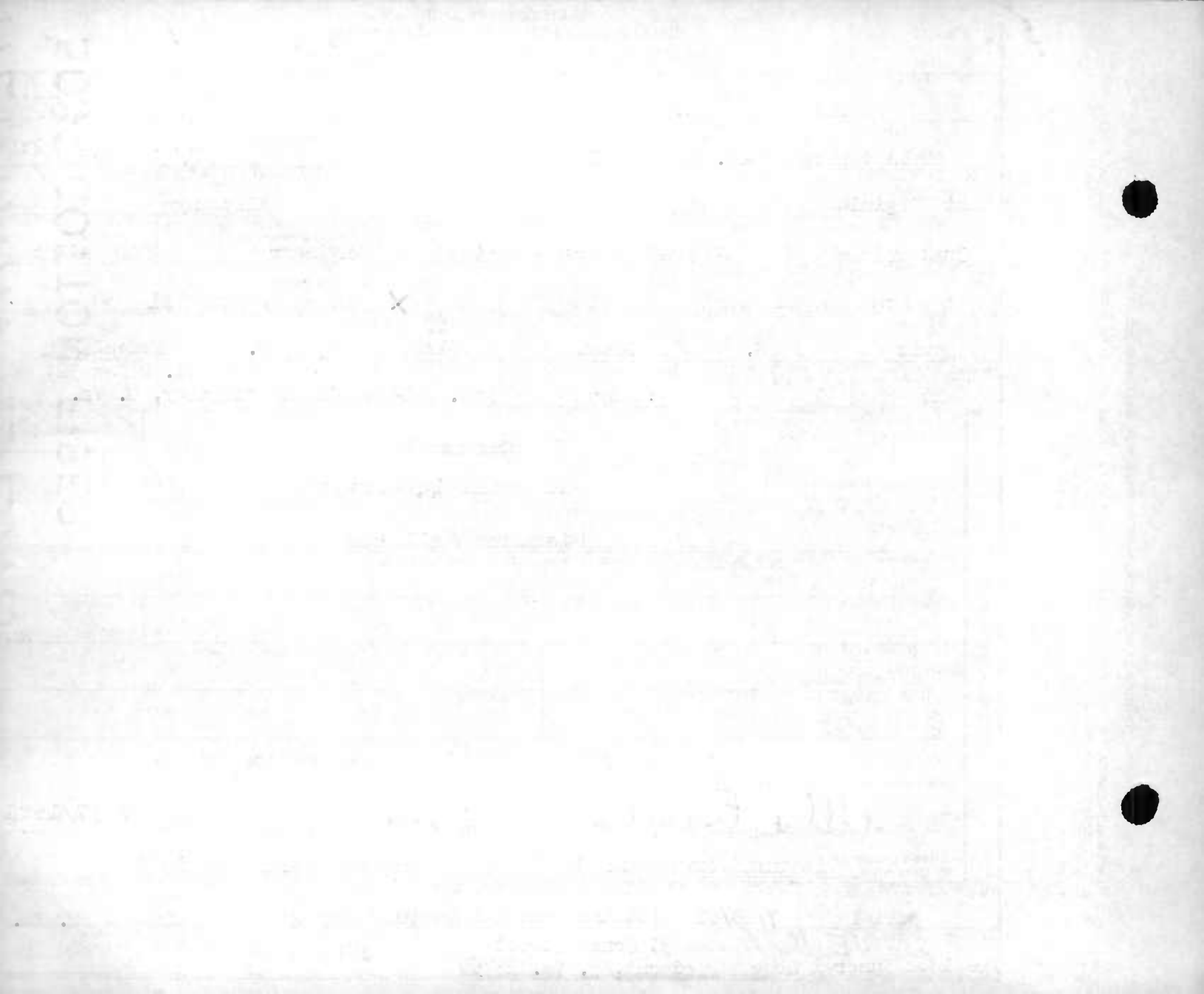
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Lch

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17025	
1. FOR STATE REGISTRAR							2a. DATE KNOWN OF DEATH			2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST							2c. DATE PRONOUNCED DEAD			2d. HOUR	
Louis E. Green							7/17 1981			12:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male		White		Nov. 16 '07		73 YRS.				7/17 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
West Virginia				USA						Allegany MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				Sacred Heart Hospital				Engineer		B&O Railroad	
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
West Virginia				Mineral				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt # 2, Box 321	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.			
Lewis S. Green				Ola E. Fazenbaker				216-07-2302			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
No				216-07-2302				Mrs. Roberta Green			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)				Pneumonia							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				Bacterial Infection							
(b)				Diabetes Mellitus							
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Giovanni Mastrangelo				M.D. Deputy				7/17/1981			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Giovanni Mastrangelo				Sacred Heart Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				7/20/81				Potomac Memorial Gardens			
23d. LOCATION				23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE			
Keyser				JUL 23 1981				Mineral W. Va.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME Fredlock Funeral Home				ADDRESS 31 Jones Street				25c. REGISTRAR'S SIGNATURE			
				Piedmont, W. Va. 26760							



8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17026	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Paul M. Gurtler</b>										2a. DATE KNOWN OF DEATH <b>7-13 19 81</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>Oct. 26, 1919</b> 6. AGE (IN YEARS) <b>61</b> YRS.										2b. DATE PRONOUNCED DEAD <b>July 13 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD	
10. CITY OR TOWN OF DEATH <b>Cumberland</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>201 Columbia St.</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State Highway Adm.</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>State Md.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Allegany</b> 13c. CITY OR TOWN <b>Cumberland</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>201 Columbia St.</b>											
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Charles Gurtler</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Emma Twigg</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>War II</b> 16b. SOCIAL SECURITY NO. <b>236-14-1047</b> 17. INFORMANT ADDRESS <b>Wife Mrs. Othelia Gurtler, 201 Columbia St.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cardiac Arrhythmia</b> <b>4265</b> IMMEDIATE CAUSE (a) <b>Bundle Branch Block</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Hypertensive Cardiovascular Disease</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Paul</b> TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER DATE SIGNED <b>7-14-1981</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Paul Snow</b> ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>7-16-1981</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Forest Glen Cemetery</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenspring, W. Va.</b>											
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS										25a. DATE REC'D. BY REGISTRAR <b>JUL 21 1981</b> 25b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

Lch

BP  
DHMH-17  
(VR A15 ME (1))  
15M 2/80



1023-41-7

• 20 • *Journal of the American Academy of Child and Adolescent Psychiatry*

100 100 100

51. *Amphiprion*, *Amphiprion*, 3. 1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	7	0	2	7				
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH									
Ralph L. Haney										MONTH		DAY		YEAR		2b. HOUR			
										07		05		81		3:30 p.m.			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR			7 UNDER 24 HRS				
Male			White			MONTH DAY YEAR 01 15 15			66 YRS.			MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
Kingwood, W.Va.			U.S.A.						Allegany County MD.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Frostburg			Frostburg Community Hospital							Foreman			Electric Co.						
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland										Allegany		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 3 Box 365			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST					FIRST MIDDLE LAST														
Lloyd Haney					Mary Meaner														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17 INFORMANT ADDRESS									
Yes					W.W. 2					215-10-4726A					Mrs. Doris Haney, Rt. 3, Box 365 Frostburg, Md. 21532				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) <i>Squamous Cell Carcinoma of the Lung</i>										6 yrs. ?!									
1629 DUE TO, OR AS A CONSEQUENCE OF (b)																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										NONE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
N/A			✓			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
N/A			P.M. ✓ 19			✓													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE										
						✓													
22a. I certify that (I) (his hospital) attended the deceased from <i>MARCH</i> 19 <i>81</i> , to <i>07-05</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>07-05</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <i>saw the body after death</i> .										22c. DATE SIGNED									
22b. SIGNATURE <i>Martin Rothstein</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										07/06/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
Martin Rothstein, M.D.										48 Broadway St., Frostburg, Md. 21532									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE										
Burial			July 7, 1981			Eckhart Cemetery			Eckhart, Allegany, Md.										
24 FUNERAL DIRECTOR NAME ADDRESS										24b. DATE OF REGISTRATION									
Durst Funeral Home, Frostburg, Md. 21532										7-10-81									

First Funeral Home, Prospect, Md. 21222

Funeral

July 7, 1981 Robert Cemetery

Prospect, Maryland, Md.

711 Westview, N.E.

48 Broadway St., Prospect, Md. 21222

First Funeral Home

Wife  
Wife

Yon

W. L. S

212-27-4756

from Doris Hanes, Prospect, Md. 21222  
Rt. 3, Box 302

Lloyd

original, African

Prospect

X

Rt. 3 Box 302

Foreman

Prospect Community Hospital

Prospect

Prospect Co.

Prospect, Md.

Attorney General

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 1 1 7 0 2 8	
1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RUTH DEVORE HANLIN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 10, 1981</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 13 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USXX WVA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H. WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>WVA.</b>		13b. COUNTY <b>MINERAL</b>	
13c. CITY OR TOWN <b>KEYSER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>RT. 2</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL WILT</b>	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA GAVERT</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>234 14 6947</b>		17. INFORMANT ADDRESS <b>MARY AGNES CARNELL KEYSER, WV.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			
19a. DATE OF OPERATION <b>23 June 81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Same</b>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE <b>122 S. CENTER STREET, CUMBERLAND, MD 21502</b>		21f. SIGNATURE DEGREE <b>FRED MILTENBERGER, M.D.</b>	
21g. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRED MILTENBERGER, M.D.</b>		21h. ADDRESS <b>122 S. CENTER STREET, CUMBERLAND, MD 21502</b>	
22a. CERTIFY THAT (1) (this hospital) attended the deceased from <b>21 June 81</b> to <b>10 July 81</b> that (2) (we) last saw the deceased alive on <b>9 July 81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. DATE SIGNED <b>10 July 81</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/12/81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>POTOMAC MEMORIAL GARDEN KEYSER, MINERAL, WV.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>111 CHURCH STREET BOAL'S FUNERAL HOME; WESTERNPORT, MD 21562</b>	

JUL 20 1981

**• VY**

155

0 18 ylf 01 18

✓

125 S. CENTRE STREET, CHICAGO, ILL. 60605

0.4 573739 07 JAN 1987

10/2/77

1000 1/2 PINEAL HOLT WESTERHOLM, MD 21288

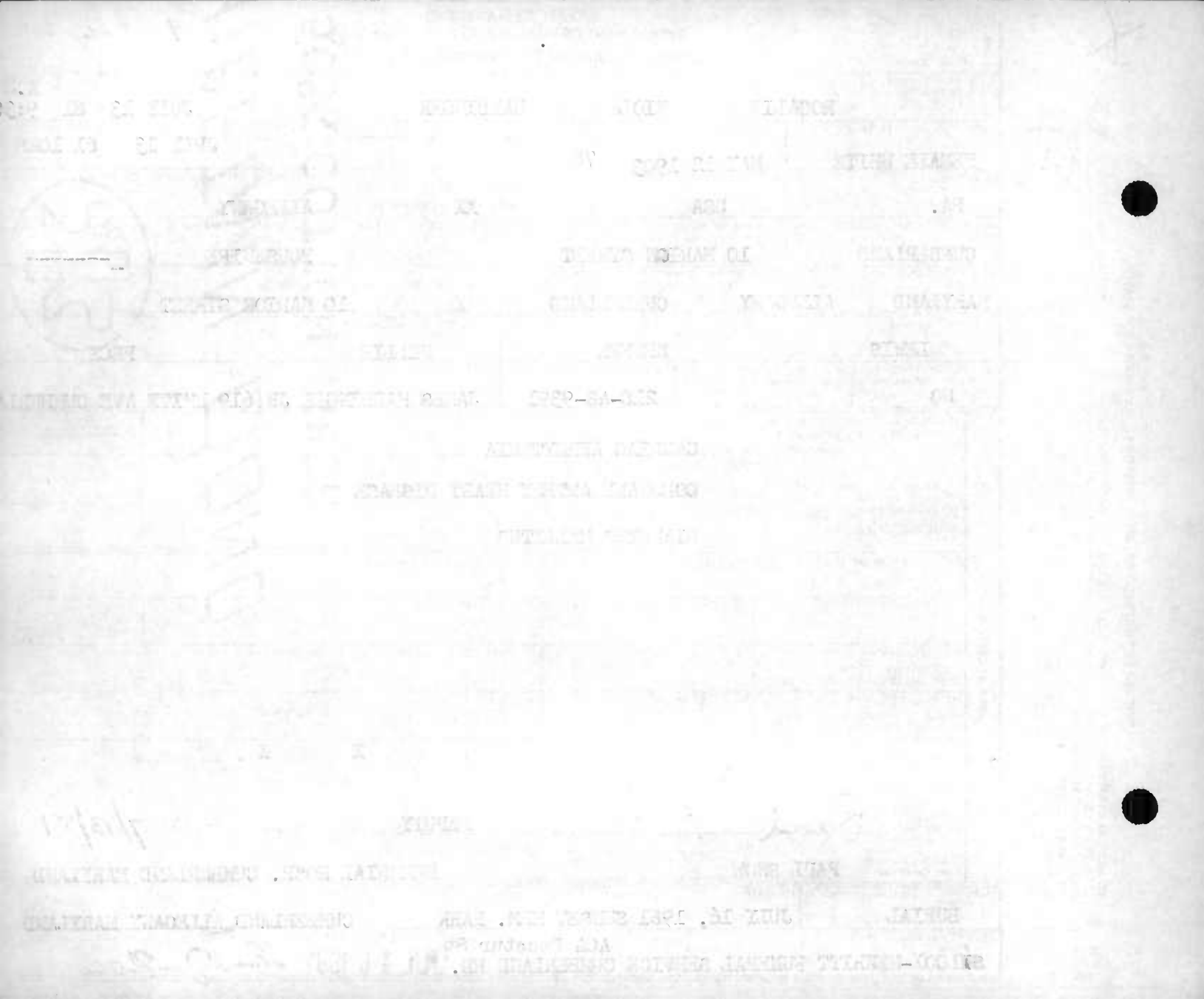
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17029	
1. DECEASED NAME (TYPE OR PRINT) <b>ROSALIE VIOLA HARDINGER</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <b>JULY 13, 1981</b>		2b. HOUR <b>9:30</b>		2c. DATE PRONOUNCED DEAD <b>JULY 13, 1981 10AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>12</b> YEAR <b>1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YR. MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10 MARION STREET</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY _____	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10 MARION STREET</b>			
14. FATHER'S NAME FIRST <b>LEWIS</b> MIDDLE _____ LAST <b>KEEFER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>NELLIE</b> MIDDLE _____ LAST <b>PECK</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>218-48-9391</b>		17. INFORMANT ADDRESS <b>JAMES HARDINGER JR 619 WHITE AVE CUMBERLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITUS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Paul Snow</b>				TITLE (SPECIFY) <b>DEPUTY</b>				MEDICAL EXAMINER		DATE SIGNED <b>7/13/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL SNOW</b>				ADDRESS <b>MEMORIAL HOSP. CUMBERLAND MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JULY 16, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEM. PARK</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>ST LOOX-MERRITT FUNERAL SERVICE</b> ADDRESS <b>404 Decatur St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>					

MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1-7030	
1. DECEASED NAME (TYPE OR PRINT) <b>John J. Hargosh</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		2b. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 22, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>7-31 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.		
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>57 Hill Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Street Dept.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>57 Hill St.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Hargosh</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Pavlick</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>W.W. 2 220-10-2154</b>		17. INFORMANT ADDRESS <b>Mrs. Helen Harris, Frostburg, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 Congestive Heart failure of</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>long duration, recently aggravated.</b> (b) <b>long duration, recently aggravated.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francisco Reyes</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>7-31-81 Md.</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes, M.D.</b>				ADDRESS <b>Sacred Heart Hosp., Cumberland,</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 3 '81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>						24b. DATE REC'D BY REGISTRAR <b>AUG 10 1981</b>		24c. REGISTRAR'S SIGNATURE			

2007-04-10 10:20

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL DIRECTOR MUST SIGN AND DATE THE CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL HOME; PAGES 4 AND 5 TO THE BURIAL CREMATION. PAGES 6 AND 7 TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WEST BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M 2/80

1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				7 0 3 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MAYBELLE		MIDDLE E.		LAST GALL KISER	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 12 13		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CUMBERLAND MEMORIAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY P.G.CO. SCHOOL	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WARREN NORRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAYBELLE HOBBS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-24-4033	
17. INFORMANT ADDRESS Chart. Memorial Hospital							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) arteriosclerotic coronary artery disease (c) in diabetic background.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Francisco Jeyes		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED July-27-81	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-30-1981		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.	
24. FUNERAL DIRECTOR Arthur Welter		25a. DATE REC'D. BY REGISTRAR JUL 31 1981		25b. REGISTRAR'S SIGNATURE James J. Welter			
25c. ADDRESS Takoma Funeral Home 254 Carroll St. N. W.							

10 1

WARREN COUNTY

WARREN COUNTY

WARREN COUNTY

WARREN COUNTY

WARREN COUNTY

No

WARREN COUNTY

WARREN COUNTY

WARREN COUNTY

WARREN COUNTY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Naomi NMI Kroll</b>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>7 26 1981</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 17 903</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>77</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN <b>77</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Alleg</b>	13c. CITY OR TOWN <b>Midland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Filer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nannie Fatkin</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213 74 3297</b>		17. INFORMANT ADDRESS <b>Beverly Blair Midland, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Most likely Myocardial Infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arteriosclerotic Heart disease</b> (c) <b>1 hour</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Francisco Reyes</b>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER DATE SIGNED <b>July-26-81</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco REYES</b>		ADDRESS <b>900 Seton Dr. Cumberland, Md. 21502</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/29/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
24. FUNERAL DIRECTOR NAME <b>Eichhorn Funeral Home</b>		ADDRESS <b>Lonaconing, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 29 1981</b>
		25b. REGISTRAR'S SIGNATURE <b>Shane J. Martin</b>		



LIBRARY  
MUSEUM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>DEWEY CALVIN LLEWELLYN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 25, 1981</b>		2b. HOUR <b>4:09 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 3, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>						13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dewey Llewellyn</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Naomi Llewellyn</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>2 W.W. 218-16-3546</b>		17. INFORMANT ADDRESS <b>Rosalie Llewellyn Rt.1 Frostburg, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Congestive Heart Failure, Arrhythmias</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> <b>7 wk.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic coronary artery disease.</b> <b>years.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic obstructive lung disease.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>24 July 1981</b> to <b>25 July 1981</b> that (I) (we) last saw the deceased alive on <b>25 July 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR. THOMAS J. DEVLIN</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-27-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. THOMAS J. DEVLIN</b>				22e. ADDRESS <b>55 JACKSON ST. LONA CONING, MD 21539</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/28/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lairtel Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Moscow A. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>EICHORN FUNERAL HOME LONA CONING, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Devlin</b>			



4-000

JULY 25 1981

DERBY CALVIN LEEWELLYN

ALLEGANY COUNTY

SACRED HEART HOSPITAL

6.1 ex 103

25 JACKSON ST. LONACONING, MARYLAND

DR. THOMAS J. DEVLIN

EICHORN FUNERAL HOME LONACONING, MARYLAND 21501  
MAIN STREET

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17034	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Alden Homer Lowery</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <b>7/16/81</b>		2b. HOUR <b>3:05 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7/13/1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>7/16/81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD		
10. CITY OR TOWN OF DEATH <b>Ellerslie</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at Home in Ellerslie, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Celanese, Ret.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Textiles</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Ellerslie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Lowery</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Luman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>217-10-4612</b>		17. INFORMANT ADDRESS <b>Edna Wilson Lowery, Ellerslie, Md. 21529</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>5996</b> IMMEDIATE CAUSE (a) <b>Probable Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Urinary Infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Obstruction of urinary flow</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Lymphoma</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7/16/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo, M.D.</b>				ADDRESS <b>Sacred Heart Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 18, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cooks Mills Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyndman RD#1 Bedford Co., Pa.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harvey H. Zeigler, Hyndman, Pa. 15545</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James O. Norton</b>			



NOTION

WINTER

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8117035	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH EDWARD LUECK				2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1981			2b. HOUR PM 2:30 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1913		6. AGE (IN YEARS LAST BIRTHDAY) YRS 67		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Rail Road		
13a. STATE MD			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1004 Oldtown Road		
14. FATHER'S NAME FIRST MIDDLE LAST Frank John Lueck						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Gessenhouse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Agnes M. Lueck Cumberland, MD Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic encephalopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral aneurysm</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>81</u> , to <u>7/30</u> , 19 <u>81</u> , that (I) (we) lost <u>saw the deceased alive on 7/30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>7/31/81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SANETA			22e. ADDRESS MEMORIAL HOSPITAL/ICU DEPT.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-3-81		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR JAMES F. SCARPELLI CUMBERLAND, MD 21502						25a. DATE REC'D. BY REGISTRAR AUG 3 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



RECEIVED 1960

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

7. [Illegible text]

8. [Illegible text]

9. [Illegible text]

10. [Illegible text]

11. [Illegible text]

12. [Illegible text]

13. [Illegible text]

14. [Illegible text]

15. [Illegible text]

16. [Illegible text]

17. [Illegible text]

18. [Illegible text]

19. [Illegible text]

20. [Illegible text]

21. [Illegible text]

22. [Illegible text]

23. [Illegible text]

24. [Illegible text]

25. [Illegible text]

26. [Illegible text]

27. [Illegible text]

28. [Illegible text]

29. [Illegible text]

30. [Illegible text]

31. [Illegible text]

32. [Illegible text]

33. [Illegible text]

34. [Illegible text]

35. [Illegible text]

36. [Illegible text]

37. [Illegible text]

38. [Illegible text]

39. [Illegible text]

40. [Illegible text]

41. [Illegible text]

42. [Illegible text]

43. [Illegible text]

44. [Illegible text]

45. [Illegible text]

46. [Illegible text]

47. [Illegible text]

48. [Illegible text]

49. [Illegible text]

50. [Illegible text]

51. [Illegible text]

52. [Illegible text]

53. [Illegible text]

54. [Illegible text]

55. [Illegible text]

56. [Illegible text]

57. [Illegible text]

58. [Illegible text]

59. [Illegible text]

60. [Illegible text]

61. [Illegible text]

62. [Illegible text]

63. [Illegible text]

64. [Illegible text]

65. [Illegible text]

66. [Illegible text]

67. [Illegible text]

68. [Illegible text]

69. [Illegible text]

70. [Illegible text]

71. [Illegible text]

72. [Illegible text]

73. [Illegible text]

74. [Illegible text]

75. [Illegible text]

76. [Illegible text]

77. [Illegible text]

78. [Illegible text]

79. [Illegible text]

80. [Illegible text]

81. [Illegible text]

82. [Illegible text]

83. [Illegible text]

84. [Illegible text]

85. [Illegible text]

86. [Illegible text]

87. [Illegible text]

88. [Illegible text]

89. [Illegible text]

90. [Illegible text]

91. [Illegible text]

92. [Illegible text]

93. [Illegible text]

94. [Illegible text]

95. [Illegible text]

96. [Illegible text]

97. [Illegible text]

98. [Illegible text]

99. [Illegible text]

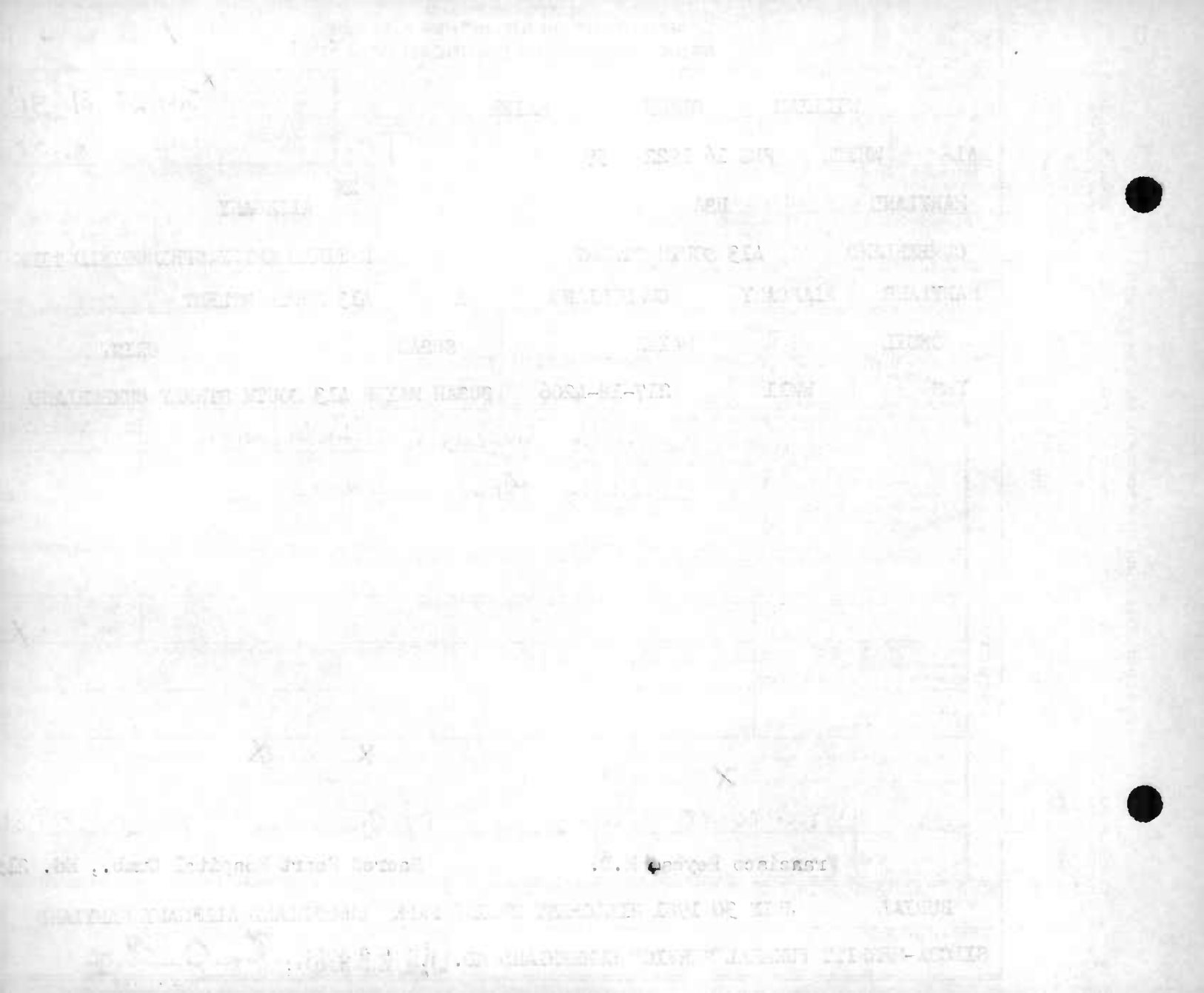
100. [Illegible text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM GLENN MATER</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>July 27 19 81</b>		2b. HOUR <b>3 P.M.</b>				
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 16 1922</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>59</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>July 27, 81</b>		2d. HOUR <b>3 P.M.</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>413 SOUTH STREET</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED KELLY SPRINGFIELD TIRE</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>413 SOUTH STREET</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>CECIL MATER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN CRIST</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 217-18-4206</b>		17. INFORMANT <b>SUSAN MATER 413 SOUTH STREET CUMBERLAND</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probably Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary Artery disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Francisco Reyes</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER				DATE SIGNED <b>July-27-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francisco Reyes, M.D.</b>		ADDRESS <b>Sacred Heart Hospital Cumb., Md. 21</b>									
23a. BURIAL, CREMATION, REMOVAL (SPEC.) <b>BURIAL</b>		23b. DATE <b>JULY 30 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MARYLAND</b>			
24. FUNERAL DIRECTOR <b>SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.</b>						25a. DATE REC'D BY REGISTRAR <b>JUL 29 1981</b>					
ADDRESS						REGISTRAR'S SIGNATURE <i>Francisco Reyes</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DELIA Louise MARTIN					2a. DATE OF DEATH MONTH DAY YEAR JUNE 26, 1981			2b. HOUR 3:54A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.				
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland					13b. COUNTY Allegany		13c. CITY OR TOWN Little Orleans		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Conrad E. Kelley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clora B. Perry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 07 1214		17. INFORMANT ADDRESS Ollin R. Gloyd same as 13						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compensatory Failure</u> <u>4360</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Body C. V.A.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated Peptic Ulcer</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 weeks</u> <u>2 weeks</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>										
19a. DATE OF OPERATION <u>6/1/81</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Perforated Peptic Ulcer</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> , 19 <u>81</u> , to <u>6/26</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Richard L. Snider</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/29/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. RICHARD L. SNIDER				22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-29-81		23c. NAME OF CEMETERY OR CREMATORY Greenway Cenetry		23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Springs Morgan W.Va.				
24. FUNERAL DIRECTOR NAME <u>Richard J. Home Hancock MD</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 13 1981</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

DATE OF TEST

TIME

BY

DEPT.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TEST NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17038	
1. DECEASED NAME (TYPE OR PRINT) <b>Gary Wayne McClung</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 15 1981		2b. HOUR 23:20			
3. SEX <b>Male</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 9 40</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <b>41</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7 15 1981		2d. HOUR 23:20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Microdyne Corp.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Paul Mc Clung</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luey Edna Davis</b>			13e. STREET ADDRESS <b>Rt. 6 Box 204</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>212-38-7139</b>		17. INFORMANT ADDRESS <b>Penny Mc Clung Cumberland, Md</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Muliple head injuries</b> 8191 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Automobile accident</b> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>23:00 7/15/ 1981</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>23:00 7/15/ 1981</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Automobile accident-passanger</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <b>Highway</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Highway</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 28 South, Ft. Ashby West Virginia</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Paul Snow</b>			M.D. <b>Paul Snow</b>			MEDICAL EXAMINER		DATE SIGNED <b>7/16/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow, M.D.</b>			ADDRESS <b>Memorial Hospital Cumberland Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7 20 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland Allegany Md</b>				
24. FUNERAL DIRECTOR NAME <b>David A. Burdock</b>			ADDRESS <b>Kitzmiller, Md</b>			25a. DATE RECEIVED BY REGISTRAR <b>JUL 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

LETTER DOWN

10

10/11

8 1 1 7 0 3 9

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM E. MC DANIEL			2a. DATE OF DEATH MONTH DAY YEAR JULY 11, 1981			2b. HOUR 6:10P M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 13, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ballistics Lab.		12b. KIND OF BUSINESS OR INDUSTRY Ret. Sta. Eng.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John R. McDaniel				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LiVina Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-34-0726		17 INFORMANT ADDRESS Ivan C. McDaniel, Cumberland, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE LEUKEMIA</u> <u>2080</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CORONARY ARTERY DISEASE WITH ATRIAL FIBRILLATION</u>			
--	--	--	--

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (it (this hospital) attended the deceased from saw the deceased alive on <u>7/11/81</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (it (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Shirley A. Nathan</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A.S. NATHAN				22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MARYLAND 21502			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 14, 81		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial P.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
---	--	--------------------------	--	---	--	---	--

24 FUNERAL DIRECTOR NAME ADDRESS Right Funeral Home, Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR JUL 17 1981		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Nathan</u>	
--	--	--	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Harold E. McKenney		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH JULY 10 1981		DAY 10		YEAR 81		2b. HOUR 12:51 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 14 1922		6. AGE (IN YEARS) LAST BIRTHDAY 59 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH JULY 10 1981		DAY 10		YEAR 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany													
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (DOA) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machanic		12b. KIND OF BUSINESS OR INDUSTRY Concrete													
13a. STATE MA		13b. COUNTY Middlesex		13c. CITY OR TOWN Acton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 North Street											
14. FATHER'S NAME FIRST MIDDLE LAST Norris Fenton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennette Evelyn Sables																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 023-16-7227		17. INFORMANT H. Flourine McKenney		ADDRESS Acton, MA													
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Probable Coronary Occlusion Coronary Artery Disease (c) Arteriosclerosis														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		Giovanni Mastrangelo, M.D.										TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER		DATE SIGNED 7/10/1981					
EXAMINER'S NAME (TYPE OR PRINT)		Giovanni Mastrangelo, M.D.										ADDRESS Cumberland, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JULY 14, 1981		23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN CREMATION		23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE Middlesex MASS													
24. FUNERAL DIRECTOR NAME DAVID W. BADGER		ADDRESS 347 King St. Littleton Mass		25a. DATE REC'D. BY REGISTRAR JUL 16 1981		25b. REGISTRAR'S SIGNATURE													



2

March 1, 1900

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 28th inst.

in relation to the matter of the proposed extension of the term of the lease of the land.

I have conferred with the proper authorities and they have decided to grant the extension.

Very respectfully,

Yours very truly,

Wm. H. H. H.

Enclosed for you are the necessary papers.

I am, Sir, very respectfully,

Sincerely yours,

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

Wm. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8117041	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ADELE LAST METZ			2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1981		2b. HOUR 7:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3/29/1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK, LOCATION OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Allegany 13c. CITY OR TOWN Lonaconing			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 2 Island Street		
14. FATHER'S NAME FIRST John MIDDLE W. LAST Walsh			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Berkenbaugh LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Catherine L. Smith Baltimore, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 27, 1981, to July 28, 1981, that (I) (we) last saw the deceased alive on July 27, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leslie Miles, M.D.		DEGREE MD		22c. DATE SIGNED 7-28-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LESLIE MILES, M.D.		22e. ADDRESS 55 JACKSON STREET, LONA CONING, MD 21539			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/30/81		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
				23d. LOCATION Lonaconing A. Md STATE	
24. FUNERAL DIRECTOR NAME EICHORN FUNERAL HOME,		ADDRESS MAIN STREET LONA CONING, MD 21539		25a. DATE REC'D. BY REGISTRAR AUG 3 1981 25b. REGISTRAR'S SIGNATURE	

BP

71

7125

JULY 28 1981

NETT

ADOLE

MARY

ALLEGANY COUNTY

SACRED HEART HOSPITAL

Chapman

Berkeley

Barry

Wolfe

W.

John

no

55 JACKSON STREET, MONROVIA, MD

LESLIE HILLES, M.D.

7/30/81

trial

ELCHORN FUNERAL HOME, LONACONING, MD 21229  
MAIN STREET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 7 0 4 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
DAVID		NORMAN		MILLER		JULY 12, 1981		1:18A				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Sept. 23, 1907		73		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		USA				Allegany						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		MEMORIAL HOSPITAL		Retired		Auto Supply Co.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		628 Easst Oldtown Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Edward Miller		Myrtle Roache											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
no		214-05-5914		Mrs. Ruth J. Miller, Cumberland, Md. Wife									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Coronary Artery Disease.</u> <u>4149</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Mitral Regurgitation</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asystole.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
N. P. SAHETA		MD				7-15-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
N. P. SAHETA		MEMORIAL HOSPITAL CUMBERLAND, MARYLAND 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		7-16-1981		Hillcrest Burial Park		Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.				JUL 21 1981		Ruth J. Miller							

DAVID  
-1000-  
1150  
JUN 11 1941  
1111A

TO  
A. C. JONES  
1150  
1111A

CUMBERLAND MEMORIAL HOSPITAL

1150  
1111A

1150  
1111A

1150  
1111A

CUMBERLAND MEMORIAL HOSPITAL

1150  
1111A

1150  
1111A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
FOR 1. STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		7b. HOUR		P.	
Joseph A. Minke			July		7, 1981		9:40								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		WHITE Caucasian		MONTH 08 DAY 04 YEAR 1900		80 YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				Allegany MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Lions Manor Nursing Home				Game Warden, RET				STATE					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland			Allegany		Cresaptown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12612 Valley View Ave.						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
John				MARY				Hipshman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Unknown				215-36-8771		Lions Manor N.H., Seton Drive, Cumb. MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4860 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD, Dementia</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
<u>George Breza MD</u>								7/7/81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
George Breza, M.D.				Seton Drive, Cumberland, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				7-11-1981		SS. PETER & PAUL CEMETERY				CUMBERLAND ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				26. REGISTRAR'S SIGNATURE							
LEASURE*STEIN FUNERAL HOME, INC. CUMBERLAND, MD				JUL 15 1981				<u>James J. Nathan</u>							

7 1901 2:10

July

July

..

Location

Name

Continued

00

of 1900

00

Northland

USA

x

Allegany

Grubbs and

James John Harding

Gene Harding

and

Allegany

Washington

x

12012 Valley View Ave.

John

John

Illinois

Washington

212-36-8771

James John Harding, N.H., 2000 Twelve, Wash. D.C.

George Brown, N.H.

2000 Twelve, Wash. D.C. 21202

7-11-1-01

Washington, D.C. 2000 Twelve, Wash. D.C. 21202



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Francis R. Monahan</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>7-4</b> 19 <b>81</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH (MONTH DAY YEAR) <b>Sept. 7, 1915</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>July 4</b> 19 <b>81</b>		7b. HOUR <b>10</b> PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Cresaptown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brant Road, Cresaptown</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Insurance Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance Co.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cresaptown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Brant Road</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Hugh Monahan</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Matilda Sperry</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>War II</b>				16b. SOCIAL SECURITY NO. <b>214-07-2387</b>		17. INFORMANT ADDRESS <b>Mrs. Regina Monahan, Cresaptown, Wife</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Sepsis</b> <b>1850</b> IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Prostate</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dr. Giovanni Mastrangelo</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER		DATE SIGNED <b>7-4-1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Giovanni Mastrangelo MD</b>						ADDRESS <b>Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 8, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

James A. Thompson

July 1, 1911

My dear Sir,

I have your letter of the 26th inst.

and am glad to hear that you are

interested in the proposed

amendment to the

constitution of the

State of Illinois.

I am sure that the people of the State will

be glad to hear

of the results of the

Very truly yours,

James A. Thompson

Secretary of the State

Chicago, Illinois

Enclosed for you are

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed with the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) Basil Barker Morris					2a. DATE OF DEATH MONTH DAY YEAR July 28, 1981					2b. HOUR 04:15 am
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31 -1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany county MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Celanese Co		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 126 Jackson Street		
14. FATHER'S NAME FIRST MIDDLE LAST Winfield Scott Morris					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lida Barker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 - 07 - 3173		17. INFORMANT Eleanor Morris Lonaconing, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks years										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Chronic colitis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 27, 1981, to July 28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) visit the body after death.										
22b. SIGNATURE Leslie R. Miles, M.D.		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7.28.81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leslie R. Miles, M.D.		22e. ADDRESS 55 Jackson St., Lonaconing, MD 21539								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/30/81		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Frostburg A. Md				
24. FUNERAL DIRECTOR NAME ADDRESS Eichorn Funeral Home Main St., Lonaconing, MD										

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

JUL 31 1981

REGISTRAR'S SIGNATURE  
Renee Jean Norton



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 7 0 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK ERNEST REID			2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1981			2b. HOUR PM 1:05 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 5 1887		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Signal Blacksmith		12b. KIND OF BUSINESS OR INDUSTRY Railroad			
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1427 Willow Court		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Bridgemen Reid			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Rensch			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 214-05-7806	
17. INFORMANT Mrs. Isabell M. Reid			ADDRESS 1427 Willow Court Cumberland, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory failure 4039 DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Organic Brain Syndrome, Encephalogram spasm.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from above, (2) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 7/30/81 to 7/30/81											
22b. SIGNATURE Shan A. Nathan			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SHAN A. NATHAN			22e. ADDRESS MEMORIAL HOSPITAL MEDICAL BUILDING								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 3, 1981		23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumberland, Md			ADDRESS 404 Decatur St			25. SIGNED BY REGISTRAR REGISTRAR'S SIGNATURE					

BP

DHM-16 30M 2/80  
(VIA 15, 4)

RECEIVED  
JAN 10 1961  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO: SAC, HONOLULU  
FROM: SAC, SAN FRANCISCO  
SUBJECT: [Illegible]  
RE: [Illegible]

[Large block of illegible text, likely a memorandum body]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Paul Harry Rice</b>		2a. DATE KNOWN OF DEATH MATED <b>July 19 19 81</b>		2b. HOUR <b>5a 30</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 25, 1906</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>July 19 19 81</b>	2d. HOUR <b>9:00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Mt. Savage</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 1, Mt. Savage, Md.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tire Builder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rubber Co.</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Mt. Savage</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Rice</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Bowden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>214-05-9645</b>		17. INFORMANT ADDRESS <b>Wife</b> <b>Mrs. Olive Rice, Route 1, Mt. Savage, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>7-19-1981</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Giovanni Mastrangelo MD</b>		ADDRESS <b>Sacred Heart Hospital, Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-22-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. George Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Savage, Md. Allegany</b>	
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, III</b>				ADDRESS <b>Cumberland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 22 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli, III</b>			



500,000,000

021-01-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
CLARA MAY RITTER			JULY 27, 1981		6:14PM								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		March 24, 1907		74		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U. S. A.				ALLEGANY COUNTY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR LAST PLACE OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland,		SACRED HEART HOSPITAL				Housewife,		Own Home					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		512 Rose Hill Ave.	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			
14a. FIRST										15a. FIRST			
Frank										Clara			
14b. MIDDLE										15b. MIDDLE			
--										Frye			
14c. LAST										15c. LAST			
Green										Frye			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No,				Mrs. Shirley G. White,		Cumberland, Md. 507 Rose Hill Ave.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Acute renal failure</u>										?			
1953 DUE TO, OR AS A CONSEQUENCE OF										?			
b) <u>Possible pelvic malignancy</u>										?			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				22c. DATE SIGNED							
A.B. Flores		M.D.				7/28/81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
A.B. FLORES, M.D.		924 SETON DR., CUMBERLAND, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		7/31/81		SS. Peter & Paul Cem.		Cumberland, Allegany Maryland							
24. FUNERAL DIRECTOR		24b. NAME		24c. ADDRESS		24d. RECEIVED BY REGISTRAR		24e. DATE					
Wayne George		202 GREENE ST. EEST		CUMBERLAND, MD. 21502		AUG 3 1981							
GEORGE FUNERAL HOME													



CLARA	MAY	PITTER	JULY 27, 1901	6:10 PM
Female	White	White	74	
Residence	St. Louis, Mo.	St. Louis, Mo.	ALLEGANY COUNTY	
Occupation	Housewife	Housewife	St. Louis, Mo.	
Religion	Methodist	Methodist	St. Louis, Mo.	
Married	Yes	Yes	St. Louis, Mo.	
Spouse	John Pitter	John Pitter	St. Louis, Mo.	
Children	3	3	St. Louis, Mo.	

*[Faint, illegible handwritten text]*

GEORGE FUNERAL HOME  
202 GREENE STREET  
ST. LOUIS, MO. 63102

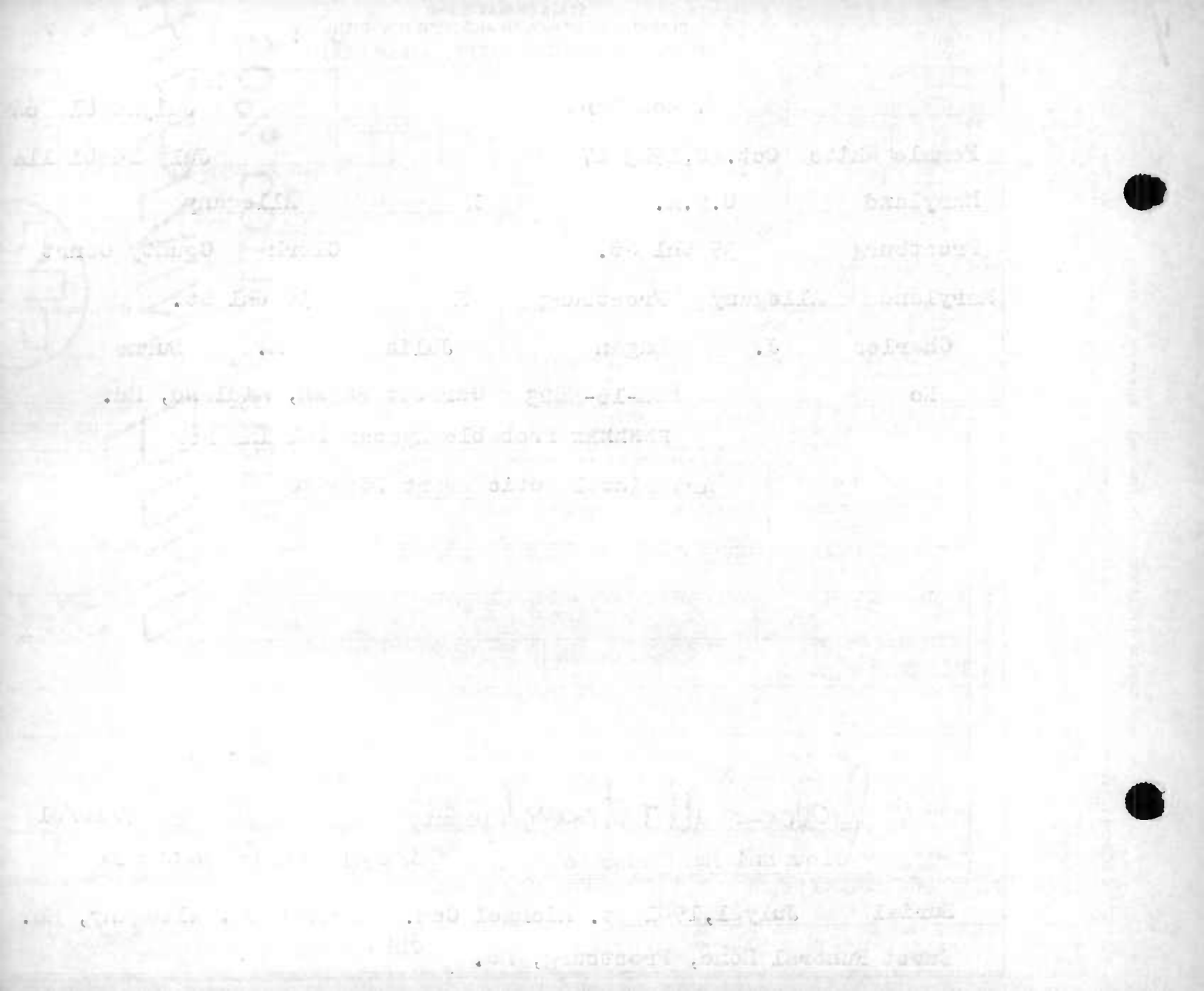
2121 N. 2nd St. St. Louis, Mo. 63102

224 SEYMOUR DR., CUMBERLAND, MARYLAND

A. B. FLORES, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17049	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Esther E. Robinson</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>July 18 1981</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 20, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>		7c. DATE PRONOUNCED DEAD <b>July 18 1981</b>		7b. HOUR <b>6AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>39 Uhl St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>County Court</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Frostburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>39 Uhl St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles J. Eagan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia M. Burns</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-16-5803</b>		17. INFORMANT ADDRESS <b>Garrett Eagan, Midland, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Probable Myocardial Infarct</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Arteriosclerotic Heart Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>7/18/81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Giovanni Mastrangelo</b>				ADDRESS <b>SACRED HEART HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 21, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Durst Funeral Home, Frostburg, Md.</b>				25a. DATE RECD. BY REGISTRAR <b>JUL 23 1981</b>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 7 0 5 0	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LEONA GLADYS RUBLE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 18, 1981</b>			2b. HOUR <b>8:30A</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 3, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>W. Va.</b> 13b. COUNTY <b>Mineral</b> 13c. CITY OR TOWN <b>Ridgeley</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 306</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold Hollen</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Kirby</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-30-8243</b>		17. INFORMANT ADDRESS <b>Mr. James M. Ruble, Jr. Ridgeley, W. Va. Husband</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1990</b> IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Week</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7/18</b> 19 <b>81</b> to <b>7/18</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <b>W. Barrera</b> DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/21/81</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. ROBUSTIANO J. BARRERA</b>					22e. ADDRESS <b>MEMORIAL HOSP. MEDICAL BLDG. CUMBERLAND, MARYLAND 21502</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-21-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS					25a. DATE REC'D. BY REGISTRAR <b>JUL 23 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

100A

JULY 16, 1961

CLINTON

100B

THE CLINTON MEMORIAL HOSPITAL  
CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI  
JULY 16, 1961

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI

CLINTON, MISSISSIPPI



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 1 1 7 0 5 1				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
WALTER NMI SCOTT					JULY 5, 1981				
3. SEX					4. RACE				
Male					White				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
March 1, 1908					73 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
Maryland					USA				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
Cumberland					SACRED HEART HOSPITAL				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Retired Eng.					Railroad				
13a. STATE					13b. COUNTY				
Maryland					Allegany				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?				
Cumberland					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Adam Scott					Isabelle Mc Corie				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					705-10-7051				
17. INFORMANT					ADDRESS				
John E. Scott, Gary, Ind. Son									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>DISC VD</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY				
					HOUR A.M. MONTH DAY YEAR				
					P.M. 19				
21d. INJURY OCCURRED					21e. PLACE OF INJURY				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]				
21f. LOCATION					CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE				
					DEGREE				
					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Dr. George Breza MD					BMG-912 SETON DR., CUMBERLAND, MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					July 8, 1981				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
SS. Peter & Paul Cem.					Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR					25. DATE RECD. BY REGISTRAR				
SCARPELLI F.H.-108 VIRGINIA AVE., CUMBERLAND, MD.					JUL 10 1981				

SCARLETT R.M.-108 VIRGINIA AVE., CHURCHLAND, MD. 21502  
July 8, 1951 55.1 star & early dawn. Churchland, Maryland, Md.  
21502

W. George Street Rd. 55-612 SETON RD., CHURCHLAND, MD. 21502

5/1/51

JO 905-11-1951 John E. Scott, Harry, Mary, on

Adam Scott Jackson, N. C. 1951

Churchland, Maryland 21502

Churchland, Maryland 21502

Churchland, Maryland 21502

Wife 21502

WALTER 21502

July 5, 1951

21502

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 7 0 5 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN <del>MARIE</del> SEAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 4, 1981</b>			2b. HOUR <b>1150A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 26, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printers Industrial</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chastine Mason</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice - (Last Name Unknown)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-22-9652A</b>		17. INFORMANT ADDRESS <b>6837 Riverdale Rd.</b> <b>Charles A. Seay Apt-101 - Riverdale, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1830</b> IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Ovary with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>abdominal metastases.</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20/81</b> , to <b>6/7/81</b> , that (I) (we) lost saw the deceased alive on <b>7/4/81</b> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Steven A. Dabrowski</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>July 5, 1981</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. A. S. NATHAN</b>					22e. ADDRESS <b>MEMORIAL MEDICAL BUILDING CUMBERLAND, MD 21502</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>					25. DATE RECD. BY REGISTRAR'S SIGNATURE <b>JUL 8 1981</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>DELLA BARCLAY SHEI R R</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 25, 1981</b>					
3. SEX <b>Female</b>					4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 18, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SACRED HEART HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Business woman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>retail</b>		
13a. STATE <b>Penna</b>		13b. COUNTY <b>Bedford</b>		13c. CITY OR TOWN <b>Hyndman</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard D'Charms Barclay</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Yutzky</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>169-07-5363</b>		17. INFORMANT ADDRESS <b>Mrs. Alice Leonard, Hyndman, Pa. 15545</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 4300 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ruptured intracranial aneurysm</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>K. Ashbey M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7/27</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. KHEDE R ASHKE R</b>				22e. ADDRESS <b>MEMORIAL HOSPITAL MEDICAL BLD., CUMB., MD.</b>						
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>July 28, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyndman, Bedford, Pa.</b>				
24. FUNERAL DIRECTOR NAME <b>ZEIGLE R FUNERAL HOME</b>				ADDRESS <b>HYNDMAN, PA. 15545</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Francis J. [Signature]</i>		

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

WILLY 22, 1981

RELLA PATOLAY ENTIRE

ALLEYWAY COUNTY

SACRED HEART HOSPITAL

Supplied information for

WILLY 22, 1981

DR. KATE FASHER

WILLY 22, 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 8117054	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbur Dixon Silis		2a. DATE OF DEATH MONTH DAY YEAR 07/19/81		2b. HOUR 12 <sup>35</sup> PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 11 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUMBERLAND	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.	
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cumberland Nursing and Convales. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. DISTRIBUTOR		12b. KIND OF BUSINESS OR INDUSTRY BREWERY
13a. STATE MARYLAND		13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES W. SILIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE SCHEAFFER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 211-05-1926		17. INFORMANT ADDRESS JOHANNA N. SILIS, CUMBERLAND, MD. 21502	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY AS. & MYOCARDIAL FIBROSIS 5 YRS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) STATUS SURGERY SMALL BOWEL OBSTRUCTION, BILAT. PLEURAL EFFUS.					
19a. DATE OF OPERATION JULY 14, 1981		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL OBSTRUCTION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 13, 1981, to JULY 19, 1981, that (I) (we) lost saw the deceased alive on JULY 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Samuel Jacobson		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-22-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL M. JACOBSON, MD		22e. ADDRESS SUPERSHING ST, CUMBERLAND MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-22-1981		23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR NAME LEASURE-STEIN FUNERAL HOME, INC.		230. BALTIMORE AVE CUMBERLAND, MD		25. INTERED BY REGISTRAR REGISTRAR'S SIGNATURE JUL 27 1981 Samuel Jacobson	



TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text, some of which are crossed out or heavily faded.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		8 1 1 7 0 5 5				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN -- SLOAN				2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1981				2b. HOUR 1840P <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 11, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Supvr.		12b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 510 Dryer Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John -- Sloan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- Wells					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-1049		17. INFORMANT ADDRESS Mr. John W. Sloan, 223 Northway Rd. Reisterstown, Md. 21136					
18. CAUSE OF DEATH (Enter only one cause per line. If multiple causes, list them in order of sequence.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Failure</i> (c) <i>CARD, ASCVD, CHF, CAD</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Emphysema</i>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, etc.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 9, 1981 to July 9, 1981, that (I) (we) last saw the deceased alive on July 9, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED 7-10-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. TERRY WILLIAMS				22e. ADDRESS MEMORIAL MEDICAL BUILDING CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/13/81		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland	
24. FUNERAL DIRECTOR NAME H. Wayne George 202 Greene St. Cumberland, Md.				25a. DATE REC'D. BY REGISTRAR JUL 15 1981		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

JULY 10 1900

STATION

---

WOOD

Memorial

MEMORIAL SERVICE

CHURCH

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

11:00 AM

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR					8 1 1 7 0 5 6 CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Dorothy Mertie Smith					July 25, 1981 3:30 pm					
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
female		white		MONTH 08 DAY 06 YEAR 1904		76		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Allegany MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Sacred Heart Hospital				Housekeeper				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST William Yeager					FIRST MIDDLE LAST Mary D Gross					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					213-74-6882		Rev. Alan D. Smith RFD #1 -Box 91 Alum Bank, Pa			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Acute M.I.										
4149 DUE TO, OR AS A CONSEQUENCE OF (b) CAD = atherosclerosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Mitral valve disease										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-16, 1981, to 7-25, 1981, that (I) (we) last saw the deceased alive on 7-25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
DR. VELANDIA					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			July 28/81		Pleasant Grove Cem		Cumberland Allegany, Maryland			
24. FUNERAL DIRECTOR NAME					25. DATE RECEIVED BY REGISTRAR					
Silcox-Merritt Funeral Service, Cumberland, Md					JUL 28 1981					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 7 0 5 7	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Mary T. Theresa Statler			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1981			2b. HOUR 5:55 P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09 08 95		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Weber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Huffman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Lions Manor Nursing Home, Cumberland, MD							
18. CAUSE OF DEATH Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. (b) <u>Cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) <u>Alzheimer's dementia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 10</u> , 19 <u>81</u> , to <u>July 22</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) (it) (did) not view the body after death.											
22b. SIGNATURE <u>Robert Eilly M.D.</u>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED July 23, 1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Eilly, M.D.					22e. ADDRESS Cumberland, Maryland 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-25-81		23c. NAME OF CEMETERY OR CREMATORY SS. Peter and Paul Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD			
24. FUNERAL DIRECTOR NAME JAMES F. SCARPELLI					ADDRESS CUMBERLAND, MD		25a. DATE REC'D BY REGISTRAR JUL 28 1981				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 7 0 5 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>WILLIAM STEIN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JULY 5, 1981</b>			2b HOUR <b>10:00AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4 28 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>ALLEGANY</b> MD.			
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>824 HARVARD AVE.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ALEX STEIN</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GELDA STEIN</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>214-05-8114</b>		17 INFORMANT ADDRESS <b>HARRY G. STEIN .824 HARVARD AVE CUMB,MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>cardiac pump failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>acute inferior myocardial infarction</b>									<b>2 days</b>  <b>3 or 4 days?</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN IMMEDIATE CAUSE <b>ventricular respiratory depression; hyperglycemia; auricular fibrillation; extrasystoles</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>Feb. 12, 1951</b> to <b>July 5, 1981</b> , that (I) (we) last saw the deceased alive on <b>July 5, 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Samuel M. Jacobson</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>July 6, 1981</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. SAMUEL M JACOBSON</b>						22e ADDRESS <b>50 PERSHING STREET CUMBERLAND, MD 21502</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b DATE <b>7-6-1981</b>		23c NAME OF CEMETERY OR CREMATORY <b>EAST VIEW CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>CUMBERLAND ALLEGANY MARYLAND</b>		
24 FUNERAL DIRECTOR NAME <b>LEASURE-STEIN FUNERAL HOME, INC. CUMBERLAND, MD</b>						25a DATE REC'D. BY REGISTRAR <b>JUL 9 1981</b>		25b REGISTRAR'S SIGNATURE <i>James J. Harrison</i>	

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

WILLIAM

STEIN

JULY 2, 1981 10:00AM

CUMBERLAND MEMORIAL HOSPITAL

cardiogenic shock

cardiac pump failure

immediate

acute inferior myocardial infarction

3 or 4 days

ventricular

respiratory depression; hyperglycemia; peripheral edema; hypertension

July 2, 81

Feb. 12, 81

July 2, 81

July 6, 1981

DR. SAMUEL M. JACOBSON

50 PERSHING STREET  
CUMBERLAND, MD 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 8117059									
1. DECEASED NAME (TYPE OR PRINT) <b>Ruie Evelyn Teter</b>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>July 28, 1981 06:08 a.m.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 8, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7. IF ELDERLY, YEAR MONTHS DAYS HOURS MIN. <b>06:08</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>W.Va.</b> 13b. COUNTY <b>Minweal</b> 13c. CITY OR TOWN <b>Wally Ford</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1, Box 23</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dannie O'Brien</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Jones O'Brien</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>232-36-9764</b>		17. INFORMANT ADDRESS <b>Roy M. Teter, Rt. 1, Wally Ford, WVa</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal failure</b> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic ca of ovaries</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-18</b> , 19 <b>81</b> , to <b>7-28</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>7-27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>John Mehanna</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-28-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John Mehanna, M.D.</b>				22e. ADDRESS <b>909-B Seton Drive, Cumberland, MD 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkins, Randolph, W.Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Tomblyn Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas O. [Signature]</b>			

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

08:00 [00] 35 yin

909-B Boston Drive, Cambridge, MA 02138

John Holman, Ed.

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 7 0 6 0

REG. NO.

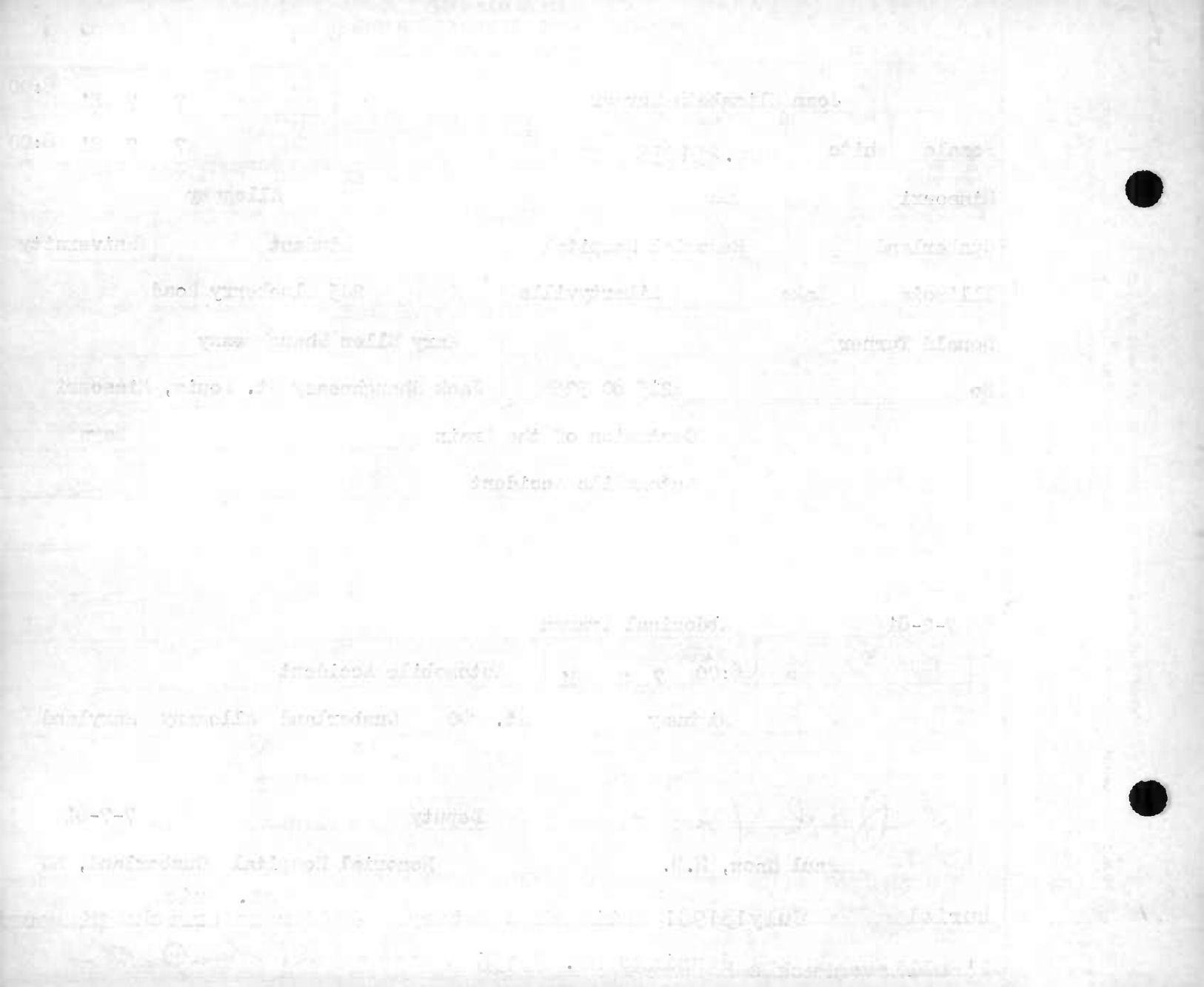
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>NORMAN E. TICHNELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 5, 1981</b>		2b. HOUR <b>1510 P</b>						
3. SEX <b>Male</b> <b>White</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS HOURS MIN. <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany County</b> MD.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cumberland</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>43 Race Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles F. Tichnell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma L. Falkenstein</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-05-4619</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Tichnell Cumberland, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Coronary artery disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Organic brain syndrome</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. Amado Torres</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>7/5/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. AMADO TORRES</b>				22e. ADDRESS <b>MEMORIAL MEDICAL BUILDING CUMBERLAND, MD 21502</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>7/6/81</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>				24a. DATE REC'D. BY REGISTRAR <b>JUL 8 1981</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17061	
1. DECEASED NAME (TYPE OR PRINT) <b>Joan Elizabeth Turner</b>										2a. DATE OF DEATH <b>7 7 81</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 25 1958</b>		6. AGE (IN YEARS) <b>22 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		2b. DATE KNOWN OF DEATH <b>7 7 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b>		2c. DATE PRONOUNCED DEAD <b>7 7 81</b>		2d. HOUR <b>8:00 P M</b>	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>University</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Illinois</b>		13b. COUNTY <b>Lake</b>		13c. CITY OR TOWN <b>Libertyville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>205 Blueberry Road</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Donald Turner</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Mary Ellen Shaughnessy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215 80 3258</b>		17. INFORMANT ADDRESS <b>Jack Shaughnessy St. Louis, Missouri</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusion of the Brain</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Automobile Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <b>8199</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>7-2-81</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Abdominal Trauma</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>6:00 AM 7 2 81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Automobile Accident</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Highway</b>				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>Rt. #40 Cumberland Allegany Maryland</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Paul Snow</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>7-7-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul Snow, M.D.</b>				ADDRESS <b>Memorial Hospital Cumberland, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>July 13 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>St. Louis Jefferson Barracks Missouri</b>			
24. FUNERAL DIRECTOR NAME <b>O'Sullivan Muckle</b>				ADDRESS <b>Jennings Mo. 63136</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

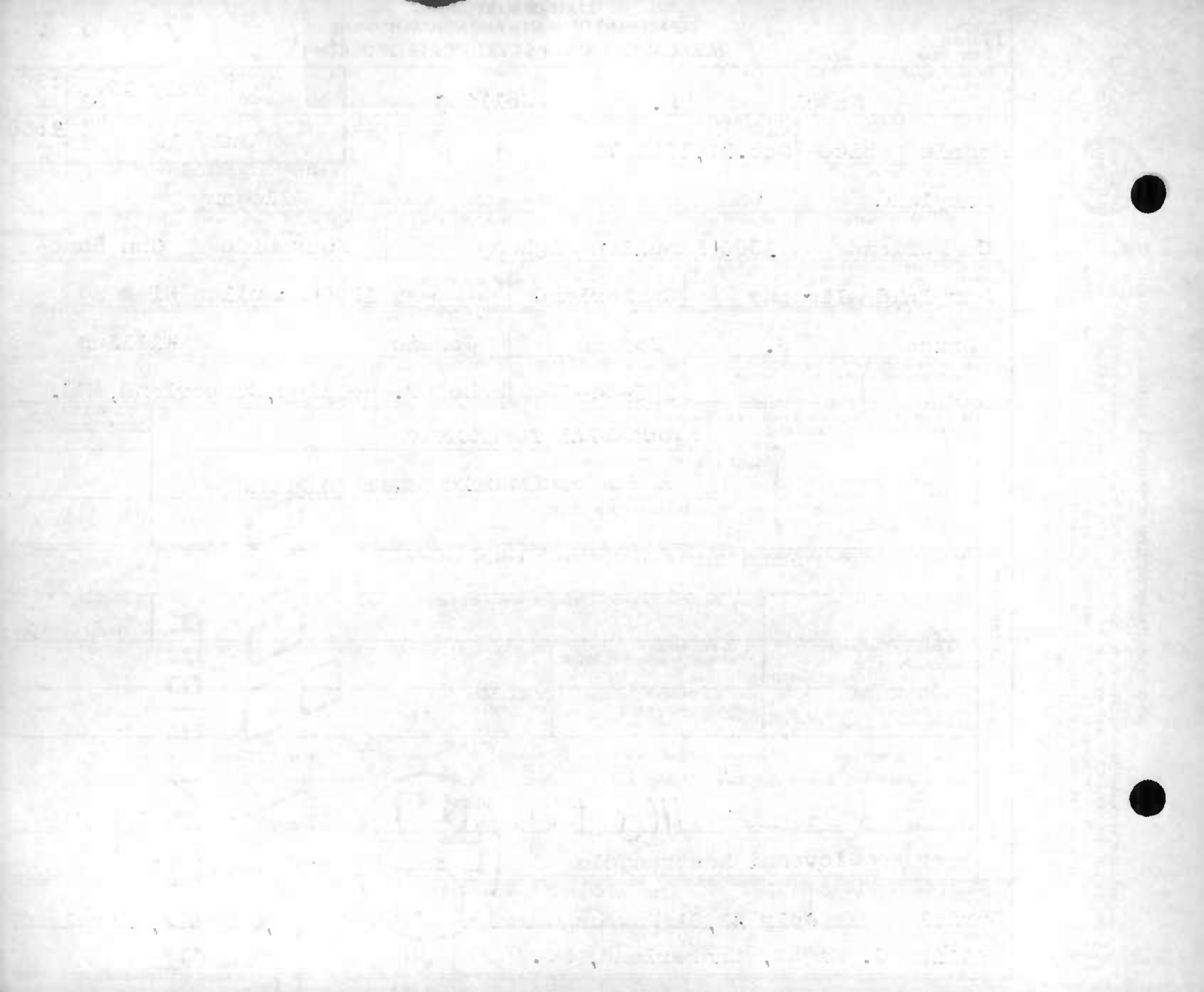




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8117062	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel M. Welling										2a. DATE KNOWN OF DEATH MONTH DAY YEAR July 19 1981	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 78		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR July 19 1981	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13001 McMullen Highway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. STATE Maryland										13b. COUNTY Allegany	
13c. CITY OR TOWN Cumberland										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 13001 McMullen Highway											
14. FATHER'S NAME FIRST MIDDLE LAST Bruce S. Forman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Killius						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 205-44-6569					17. INFORMANT ADDRESS Mabel F. Welling, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>				TITLE (SPECIFY) M.D. <i>John J. Mastrangelo</i>				DATE SIGNED 7/19/81			
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo				ADDRESS Sacred Heart Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 22, 81		23c. NAME OF CEMETERY OR CREMATORY Dawson Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Maryland	
24. FUNERAL DIRECTOR NAME William G. Knight, Cumberland, Md.						25a. DATE REC'D. BY REGISTRAR 7/23/81 REGISTRAR'S SIGNATURE <i>John J. Mastrangelo</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
 (VR A15 ME (5))  
 15M 2/80

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
STEWART RYDER WHITE								7 16 19 81				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	10/20/18		62 YRS.		MONTHS DAYS		HOURS MIN.		7 16 19 81		12:42 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Pa.		USA				Alllegany County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Sacred Heart Hospital		Consultant - Electrical		Engineering							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Virginia		Charlottesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		Lake Reynovia							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Harold Ryder White		Mary Stewart											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II 040 14 5679		Hill & Wood Funeral Home, Virginia									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7-16-81					
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Removal		7/18/81		Monticello Memorial		Charlottesville, Va.							
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
				JUL 20 1981				Name Jan Mathis					

4505 York Road, Baltimore, Md. 21215

Henry W. Jenkins & Sons Co.,

Monticello Memorial

7/18/81

Removal

VA.

Yes

WW II

040 14 2572

Hill & Wood Funeral Home, Virginia

Harold

Ryder

White

Wendy

Stewart

Virginia

Country Villa

Lake Raynoville

Consultant - Electrical  
Engineering

USA

1981

1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) SHERMAN MARTIN WILSON					2a. DATE OF DEATH MONTH DAY YEAR JULY 7, 1981			2b. HOUR 2:30 A.M.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 19, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.			
10 CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED KELLY		12b KIND OF BUSINESS OR INDUSTRY SPRINGFIELD TIRE	
13a STATE MARYLAND					13b COUNTY ALLEGANY		13c CITY OR TOWN OLDTOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST ARGYLE WILSON					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA TWIGG				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 213-22-3138		17 INFORMANT ADDRESS HAZEL WILSON RFD#1 BOX#341 OLDTOWN MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma - chronic and leukopenia</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary sepsis, from earlier vesicle.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma colon - colostomy</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 1972 Ca Rectum				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from 7-4-81, 19 to 7-7, 19 81, that (I) (we) last saw the deceased alive on 7-6, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Carla Brinsfield MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 7-8-81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. CARLTON BRINSFIELD					22e ADDRESS 401 DECATUR STREET CUMBERLAND, MD. 21502				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE JULY 9, 1981		23c NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d LOCATION CITY OR TOWN COUNTY STATE CUMBERLAND ALLEGANY MARYLAND			
24 FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD.									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>Marie Winner</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 26, 1981</b>			2b. HOUR <b>12:15 pm</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>5 23 06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.				
10 CITY OR TOWN OF DEATH <b>Frostburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frostburg Community Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY SCHOOLS</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Shaft</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Francis* PETER McDONALD</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah McCready</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO N.A.</b>					16b. SOCIAL SECURITY NO. <b>212 38 6054</b>		17 INFORMANT ADDRESS <b>MR. JOSEPH WINNER, 90 W. MECHANIC ST. FROSTBURG, MD.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCD</b> <b>4960</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>COPD</b> (c) <b>Cerebral ischemia</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Brain Syndrome</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7-13 1981</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>7-13</b> , 19 <b>81</b> , to <b>7-26</b> , 19 <b>81</b> , that (I) (we) saw the deceased alive on <b>7-26</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>H. Diehl, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7/27/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. H. Diehl</b>					22e. ADDRESS <b>Frostburg, Maryland 21532</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7/28/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FROSTBURG, ALLEGANY, MD.</b>			
24 FUNERAL DIRECTOR <b>SOWERS FUNERAL HOME</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

12:15 PM July 26, 1991

Female White 2 - 13 08  
Maryland United States  
Frostburg

Frostburg Community Hospital  
Maryland Allegany 2nd  
301 N. Lincoln Street

215 22 0084  
A.A.

ASCD  
CPB

Genetic Brain Syndrome  
Cerebral Ischemia

Dr. H. Gien  
Frostburg, Maryland 21532

RECEIVED  
JUL 27 1991  
FROSTBURG, MARYLAND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17066	
1. DECEASED NAME (TYPE OR PRINT) <b>Bernice C. Wise</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>July 2, 1981</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Feb. 25, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD <b>July 2, 1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Allegany</b> MD.	
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital DOA</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Onw Home</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>119 1/2 Arch St.</b>			
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Oscar A. Willard</b>						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Mary C. Meders</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>214-05-4573</b>		17. INFORMANT ADDRESS <b>Miss Gerville Brant, Cumberland, Niece</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4140 IMMEDIATE CAUSE (a) Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>(b) Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Giovanni Mastrangelo</b> M.D.						TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER		DATE SIGNED <b>7-2-1981</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Giovanni Mastrangelo MD</b>						ADDRESS <b>Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>July 6, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 7 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1521-9-7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		8 1 1 7 0 6 7													
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR		PM	
DARRELL MALCOLM WOTRING, Sr		JULY 21, 1981										1:30		AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		April 22, 1919		62		YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				Allegany MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL										Carpenter		Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Garrett		Mt. Lake Pk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 52							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
Raymond T. Wotring						Ella M. Hoff									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No				219-03-0157		Mrs. Marguerite E. Wotring, See #13 above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u>															
1579 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>Cerebral anoxia of the Pancreas</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>1 year</u>															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
6 months															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>21 July 19 81</u> to <u>21 July 19 81</u> , that (we) last saw the deceased alive on <u>20 July 19 81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE															
22c. DATE SIGNED															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)															
22e. ADDRESS															
DR. FREDERICK W. MILTENBERGER 122 S. CENTRE ST., CUMBERLAND, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
burial				7/24/81		Aurora Cemetery				Aurora, Preston, West Virginia					
24. FUNERAL DIRECTOR															
NAME ADDRESS															
Bradley A. Stewart Oakland, Maryland 21550															
25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE															
JUL 29 1981															

BP

1981 JULY 21 10:10

NEPHROLOGICAL HOSPITAL

CHURCHILL

WOMAN'S COLONY

WOMAN'S COLONY

DR. ROBERTSON, WILKINSON, 123 S. CENTRAL ST., CHURCHILL, IND.

1981 JULY 21